SENATE—*Saturday, August 13, 1994*

(Legislative day of Thursday, August 11, 1994)

The Senate met at 9:30 a.m., on the expiration of the recess, and was called to order by the Honorable BYRON L. DORGAN, a Senator from the State of North Dakota.

PRAYER

The Chaplain, the Reverend Richard C. Halverson, D.D., offered the following prayer:

Let us pray:

Baruch Hashem. Blessed be the Name of the Lord.

God of Abraham, Isaac, and Israel, on this Sabbath morning give us ears to hear, minds to understand, and wills to obey the foundation of all teaching in the Torah.

Hear, O Israel: The Lord our God is one Lord: And thou shalt love the Lord thy God with all thine heart, and with all thy soul, and with all thy might. And these words, which I command thee this day, shall be in thine heart: And thou shalt teach them diligently unto thy children, and shalt talk of them when thou sittest in thine house, and when thou walkest by the way, and when thou liest down, and when thou risest up. And thou shalt bind them for a sign upon thine hand, and they shall be as frontlets between thine eyes. And thou shalt write them upon the posts of thy house, and on thy gates.—Deuteronomy 6:4–9.

Baruch Hashem. Blessed be the Name of the Lord. Amen.

APPOINTMENT OF ACTING PRESIDENT PRO TEMPORE

The PRESIDING OFFICER. The clerk will please read a communication to the Senate from the President pro tempore [Mr. BYRD].

The assistant legislative clerk read the following letter:

U.S. SENATE,
PRESIDENT PRO TEMPORE,
Washington, DC, August 13, 1994.

To the Senate:

Under the provisions of rule I, section 3, of the Standing Rules of the Senate, I hereby appoint the Honorable BYRON L. DORGAN, a Senator from the State of North Dakota, to perform the duties of the Chair.

ROBERT C. BYRD,
President pro tempore.

Mr. DORGAN thereupon assumed the chair as Acting President pro tempore.

RESERVATION OF LEADER TIME

The ACTING PRESIDENT pro tempore. Under the previous order, the leadership time is reserved.

MORNING BUSINESS

The ACTING PRESIDENT pro tempore. Under the previous order, there will now be a period for the transaction of morning business not to extend beyond the hour of 10 a.m., with Senators permitted to speak therein, with the time to be controlled by the Republican leader.

Mr. KENNEDY addressed the Chair.

The ACTING PRESIDENT pro tempore. The Senator from Massachusetts.

ORDER OF PROCEDURE

Mr. KENNEDY. Mr. President, I understand that between now and 10 o'clock, there is time for morning business, and then at 10 o'clock, we return to the agreement that was outlined by the majority leader and agreed to, where we will have divided time during the course of the morning to address the health care issue; am I correct?

The ACTING PRESIDENT pro tempore. The Senator is correct.

Mr. KENNEDY. I suggest the absence of a quorum.

The ACTING PRESIDENT pro tempore. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. DOLE. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

TRIBUTE TO BOB WIKLUND

Mr. DOLE. Mr. President, I have been on the floor several times recently to recognize members of my staff who were moving on to new jobs. Sometimes they were going to a new position on the Hill.

Sometimes they were headed to K Street to work in the private sector, or elsewhere on the east coast to return to school. I even had a staffer recently who moved all the way to Colorado. But I think Bob Wiklund, a loyal member of my staff for 4 years, takes the record as he prepares to move to Belarus in the former Soviet Union.

A native of Lawrence, KS, Bob began his work in my office as an intern. He did not say too much at first, but he sure turned out a lot of work. He stepped into the duties of a legislative correspondent for foreign policy and defense, and he did so well that I decided to hire him for that job when his internship was over and we could not get him to do it for free anymore. Hiring Bob turned out to be a smart move. As our resident Russian speaker, he was very helpful during visits to my office by Mikhail Gorbachev and Boris Yeltsin. And when President Yeltsin accepted an invitation to visit my home State of Kansas, Bob was invaluable in translating letters, helping coordinate details, and acting as a liaison between my office and the Russian delegation.

After 2 years as a legislative correspondent, Bob began studying for his master's degree in international economics at the Johns Hopkins School for Advanced International Studies, but he continued to work in my office part time. This spring, Bob completed his degree and was selected by the World Bank to act as an adviser on privatization in Belarus. If his work for me is anything to go by, he will do an outstanding job. I appreciate all Bob's hard work over the years, and I wish him and his wife, Carrie, all the best in this adventure.

SALUTE TO LAURA DOVE

Mr. DOLE. Mr. President, on behalf of all my Republican colleagues, I rise to say "Thank you and good luck" to Laura Dove of the Senate Republican Cloakroom.

Today is Laura's last day in the Cloakroom, as she leaves for graduate school at the University of Virginia.

It will not be too long before Laura rivals Senator THURMOND in terms of Senate experience. Not only has she worked in the Cloakroom since May of 1992, but she also worked there from May 1987 to September 1988, and she served as a Republican page from September to December of 1986.

While at University of Virginia, Laura will also be working as a sorority housemother, and I look forward to hearing if riding herd on a bunch of college students is easier than riding herd on a bunch of Senators.

BIPARTISAN CRIME BILL

Mr. DOLE. Mr. President, finally, I would just say on the crime bill, I know we are going to be off on health care here in about 10 minutes for several hours today. It is my hope that the President, as I said yesterday, will see this not as a defeat under some procedural vote in the House but as an opportunity to work out some of the differences with Members of both parties and to indicate again that bipartisanship means you start together and you

● This "bullet" symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.

work together; you do not put it together and then ask the other party, whichever party it is, to come on board.

I am very hopeful that the President will consult with Members of both parties and take out some of the excessive spending in the package that went from a few billion dollars in the bill that passed the Senate by a vote of 95 to 4, I think it was, or 94 to 5 and then was increased, doubled, tripled, quadrupled on the House side, billions of dollars without any hearings and without much debate.

I think if that were done, and then some of the tough provisions that were dropped out of the crime bill were put back in, in my view, that would go a long way toward reaching strong bipartisan support for what is, what could be a very important piece of legislation. It is not a good bill, as the New York Times said today. It is not a good bill now, but it could be a good bill. It should be a good bill, and it should be bipartisan.

If the President is willing to work in that fashion, I think it would be helpful not only with reference to the crime bill but maybe other legislation that is pending and will be pending before we complete our work this year.

Mr. President, I suggest the absence of a quorum.

The ACTING PRESIDENT pro tempore. The absence of a quorum is noted. The clerk will call the roll.

Mr. KENNEDY. Mr. President, will the Senator withhold.

Mr. DOLE. I withhold.

Mr. KENNEDY. I thank the Senator.

Mr. President, I yield myself such time as I might use until other Members come over who wish to address the Senate in morning business, and then I will withhold the rest of my comments until later in the morning.

INSURANCE COVERAGE FOR CHILDREN

Mr. KENNEDY. Mr. President, the amendment that we will be considering today focuses on our Nation's most precious asset, our children. It improves what is already one of the strongest provisions of Senator MITCHELL's health reform proposal.

The Mitchell bill provides affordable insurance coverage for children in every American family beginning in 1997. People with incomes of less than 185 percent of poverty will be able to insure their children without any charge. Subsidies will be provided for people up to 300 percent of poverty. Comparable assistance will be provided for pregnant women.

For hard-working Americans, this bill guarantees that you will never have to choose between putting food on the table, paying a mortgage, and health care for your children.

Under the bill, if you are a family with two children and your income is less than $27,000, you will be able to insure your children at no charge. If your income is $35,000, you will pay approximately $230, less than 1 percent of your income. If you make $37,000, you will pay $1,000, but still less than 3 percent of your income. Families with $44,000 in income, the level at which subsidies phase out, will pay the full price of about $1,800, or about 4 percent of the family income.

The Mitchell bill recognizes that a health insurance card alone is not enough to guarantee timely health care for every child. So for children in the poorest school districts, the program provides Federal financial assistance for school-based or school-related health programs, under local control to make sure that children get the health services they need to do well in school and ultimately do well in life.

I must say on this point, Mr. President, one of the very, very important provisions in the Mitchell legislation, which was also in the President's program, is the development of health clinics in our schools. We have not been able to develop those kinds of programs for a variety of reasons in recent years. Anyone who has had the opportunity to visit schools, both in the inner cities, or out in rural communities, knows the kind of challenge that is out there for the children.

Mr. DASCHLE. Will the Senator yield on that point?

Mr. KENNEDY. Yes.

Mr. DASCHLE. I commend the Senator for drawing attention to the fact that school-based health clinics are one of the major focuses of the Mitchell bill.

As the Senator so eloquently has stated, there are too many occasions when students have access to no other medical care than what they now get in their schools. In some cases they do not even have access to school-based clinics. So with clinics, whether they are in rural or urban settings, we can really put meaning to the word "prevention". We can finally catch children's medical problems prior to the time that they become severe and possibly untreatable. There is no other bill pending before the Senate that emphasizes prevention like the Mitchell bill.

I am glad the Senator pointed that out. I do not know what the situation is in Massachusetts. But I know in South Dakota it is an extraordinary problem. Students today go to school with illnesses that are left undetected and untreated. We have a paucity of nurses. We have a severe shortage of nurse practitioners. We have few clinicians. We have little ability to treat children in rural areas. Under this bill, for the first time, we will be able to give students the opportunity to seek primary and preventive care.

I think the Senator is absolutely right.

Mr. KENNEDY. I thank the Senator because he brings a perspective to this of the importance in terms of the rural communities. In Arkansas, for example, they have developed these health clinics. It has taken some period of time. There was a good deal of resistance and reluctance in the initial development of those programs. I believe it took probably 2 or 3 years to develop half-a-dozen of those programs, all which involve the parents in the fashioning and the shaping of these health clinics as well as the teachers and the health professionals. Now the demand for those clinics, in rural areas as well as in the urban areas, is dramatic. They have been an extraordinary success. They are expanding on the basis of very limited resources.

We have found in my own city of Boston, that the Cambridge Rindge and Latin High School is one of the few schools in an urban area in my State that has developed a health clinic. It has a rather interesting historical background, and I will not take the time of the Senate to point out how it got developed. But it has been an extraordinary success in helping children that are coming from homes where there is abuse, physical abuse, and substance abuse; the problems in terms of hunger; the detection for example in terms of many of these illnesses at an early stage so that the child can be cured and also be participating in schools.

Many parents, hard-working parents, even when they have the children who are sick, still send their children to school because they do not have any day care to provide for them. They are endangering the other children. If you are able to have interventions in the health settings in schools, it makes an important difference.

Mr. DASCHLE. Will the Senator yield on that point?

Mr. KENNEDY. Sure.

Mr. DASCHLE. How many of those clinics does the Senator have in Massachusetts today? Does the Senator have any idea?

Mr. KENNEDY. I could probably count those school-based clinics on two hands, maybe three, but not any more.

Mr. DASCHLE. In South Dakota the situation is exactly the same. We have three or four of those clinics in the entire State. That is one of the key issues. I am glad the Senator has drawn attention to that in his remarks this morning.

Mr. KENNEDY. I want to point out to the Senator, we see our colleagues on the other side, that the provision passed 17 to nothing in our committee. It had unanimous Republican support, and Democratic support. We spent some time in fashioning and in shaping to make sure that it was really going to be reflective of local parents, local health care needs, age-appropriate kinds of interventions, but at the end of the day we were able to come together with virtually a unanimous proposal.

When we are talking, as we did briefly yesterday, about how this legislation, the Mitchell legislation, affects children, and it has been, I must say, a significant improvement over the course of the development of legislation over that which was even recommended by the President; and it is a great tribute to the work that was done by the Finance Committee, Senator MOYNIHAN, Senator RIEGLE, and others on that committee.

In addition to providing affordable coverage for every American child, the Mitchell bill establishes a standard benefit package that includes comprehensive preventive benefits for children, from prenatal care to immunizations to regular physical examinations. Every physician—and most parents, too—know that good preventive care is the best way to make sure that children get the healthy start in life that they deserve. Preventive care is cost-effective, as well. Every dollar spent on prenatal care saves more than three times as much in reduced medical costs for premature babies and other low birth-weight babies. Every dollar spent on DPT vaccinations save $30.

The Mitchell bill is really a health care bill of rights for every American child. But the Dodd amendment will make it even better. Most of the programs under the Mitchell bill are scheduled to begin in 1997, including the requirement that all insurance plans include comprehensive preventive benefits for children. This amendment starts that part of the program right away. It does not subsidize any family's purchase of insurance in advance of the 1997 implementation date. It does not add any new Government obligations. Instead, it simply says that every new insurance policy sold and every policy renewed, beginning July 1, 1995, must include comprehensive preventive benefits for children. Twenty-one States have already legislated this requirement. Many insurance policies voluntarily cover these services.

This amendment says: Let us not wait until 1997 to bring these benefits to every insured child. Let us not let a single additional child grow up disabled or suffer unnecessary illness or death because we failed to provide preventive care. The cost of this additional benefit for policies that do not already provide it is very small—about $2 per month per child, according to the Traveller's Insurance Co. But the potential value of that ounce of prevention to millions of American children is very great.

I know that many of my Republican friends in this body are strongly committed to better health care for America's children. I urge them to join us in making the Mitchell bill an even better bill for children by adopting this amendment. I urge them to buckle down and join us in the business of legislating. If they think the Mitchell bill needs improvement, let them offer amendments. If they think they have a better alternative, let them offer it—so that we can debate it in the full view of the American people.

When it comes to protection for America's children, the Republican plan simply doesn't measure up to the Mitchell bill. It doesn't achieve affordable coverage and it doesn't guarantee comprehensive preventive care without copayments or deductibles. The Mitchell plan requires coverage of clinical preventive services without any copayments or deductibles. The Republican plan requires only one benefit package to include any preventive services at all.

On the crucial issue of affordability, the Dole plan helps children in the poorest families—and, of course, the rich can always buy coverage—but it provides no assistance or protection for children in the middle-class families that work hard, play by the rules, but still can't afford the coverage they need. The Dole plan makes no coverage available especially for children, and a family earning $22,000 a year would have to pay approximately $5,900 to buy family coverage—more than a quarter of the family's total income.

I think we can do better than that for America's children. So I urge this body to adopt this amendment, and I urge my colleagues to work with us to make the Mitchell bill the best program possible for the American people—and especially for the children who are America's future.

Now before the Senate we have this very interesting proposal that has been introduced by Senator DODD and others that will extend the requirements for the inclusion of these preventive programs that were linked to children's needs in the schools.

So, Mr. President, I will come back and address this issue. I see a number of our colleagues that want to use probably the morning hour. I will come back at an appropriate time in the morning and address it.

The ACTING PRESIDENT pro tempore. Who seeks recognition?

Mr. MOYNIHAN. Mr. President, I suggest the absence of a quorum.

The ACTING PRESIDENT pro tempore. The absence of a quorum is noted. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. PACKWOOD. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

CONCLUSION OF MORNING BUSINESS

The ACTING PRESIDENT pro tempore. Morning business is now closed.

HEALTH SECURITY ACT

The ACTING PRESIDENT pro tempore. Under the previous order, the Senate will now resume consideration of S. 2351, which the clerk will report.

The legislative clerk read as follows:

A bill (S. 2351) to achieve universal health insurance coverage, and for other purposes.

The Senate resumed consideration of the bill.

Pending:

Mitchell amendment No. 2560, in the nature of a substitute.

Dodd amendment No. 2561 (to amendment No. 2560), to promote early and effective health care services for pregnant women and children.

The ACTING PRESIDENT pro tempore. The time until 5 p.m. shall be for debate only, to be equally divided and controlled by the managers of the bill or their designees. Who seeks recognition?

Mr. PACKWOOD. Mr. President, I suggest the absence of a quorum.

The ACTING PRESIDENT pro tempore. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. PACKWOOD. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

Mr. PACKWOOD. Mr. President, I yield such time as the Senator from Maine may need.

Mr. COHEN. Mr. President, I thank the Senator from Oregon. Mr. President, as the debate on health care reform rages on and Republicans are buffeted with charges of being obstructionists and incrementalists, I am filled with a sense of deja vu—perhaps in Yogi Berra's words, "deja vu all over again."

I must say I was disappointed, but not surprised, to see a story in the Washington Post that was headlined, "Senate Republicans Impede Health Care Legislation."

Mr. President, why did not the headline read: "Senate Republicans Halt Rush to Premature Amendments"?

The story also said that we spent 4 days on this legislation before the first amendment was introduced. We spent portions of 4 days. If you total up the hours spent, it might total one entire day.

As I understand it, only nine Republican Senators have had an opportunity to speak on this legislation—only nine of us. Yet, we are now accused of impeding progress on health care legislation.

Mr. President, this is legislation which we are told has been in the waiting now for some 40 or 50 years. It seems to me that taking several days to at least allow the Members to make opening statements on legislation that they and their constituents are deeply concerned about is not asking too much.

It should not be reported that we are being obstructionists just because we want to give Members the opportunity to speak, not to delay, but to at least express their opinions. Just because we want to have the opportunity to speak, we should not be labeled as obstructionists or incrementalists or accused of impeding health care legislation.

Mr. President, back in the summer of 1990, in response to what was then an emerging issue of increasing national concern, Senator DOLE charged Senator JOHN CHAFEE with the job of forming a Republican task force to develop a comprehensive proposal for national health care reform.

Over the next 3 consecutive years we met regularly—every single Thursday morning for an hour, an hour and a half, and sometimes even 2 hours—to define, discuss, and debate the problems plaguing our health care system. Sometimes we brought in experts to at least try to enlighten us about complex technical issues, such as risk adjustment. But more often than not, we talked among ourselves, discussing a multitude of issues raised by our constituents, and even about our own personal experiences with the health care system.

The problems were clear. Health care spending, which this year is expected to top some trillion dollars, was at an all-time high and rising daily, placing a strain on families and employers and governments alike. As health care costs skyrocketed, more and more Americans were being priced out of the market, leaving some 37 million or more Americans at any given time with no health care coverage whatsoever, and many more living in terror that they would lose their coverage if they became ill or changed jobs.

We all found it both ironic and tragic that under our current system, the very people who need health care coverage and treatment the most are the ones who cannot get coverage simply because they are already sick or suffering from a preexisting condition. We agreed unanimously that health care insurance should be portable; that insurers should be prohibited from denying, canceling, or limiting coverage on the basis of a person's health status.

We agreed that, rather than competing on the basis of their ability to attract the healthiest customers, insurers ought, instead, to be competing on the basis of price, quality, and service. We agreed that insurance market reforms—guaranteed eligibility and renewability, portability and limitations preexisting condition exclusions, should all be a part of any health care reform proposals.

We reached agreement on several other key components that we believed a bipartisan majority in Congress could agree upon; namely, access to health care for all Americans; subsidies for low-income individuals and families; full tax deductibility for the self-employed; encouragement of managed care and cost containment to make coverage more affordable; administrative reforms to reduce costs and paperwork and to make the system more efficient; malpractice reforms to reduce the costly practice of defensive medicine; expanded access to care in rural areas and incentives to encourage more physicians to enter primary care; stronger efforts to combat fraud and abuse which robs our health care system of as much as $100 billion a year; and, finally, greater emphasis on primary and defensive care.

These principles were part of my own legislation, which I offered back in 1990—4 years ago. It is a 76-page document. This bill which I introduced emerged as the major campaign issue in 1990 when I was running for reelection. My opponent, who favored a single-payer plan based on the Canadian system, said my approach was too complicated. This 76-page document was too complicated. We needed a simple system like the single-payer system. So it was dismissed as being too long, too involved, too convoluted and complicated. Most of the principles I just mentioned, that we have bipartisan support upon, were contained in this legislation, but it was dismissed.

Now, we have a new document which is not just 1,410 pages. I checked this morning. It has been amended for the second time and is now 1,443 pages.

Mr. President, I mentioned a moment ago that we incorporated provisions dealing with health care fraud. Over a year ago, I first introduced my health care fraud bill. As I recall, it was in May of last year. Nothing was done until November, when we passed an amendment to the crime bill, trying to come to grips with health care fraud, which, according to GAO, is costing us $100 billion a year. But even though the we passed it on our version of the crime bill, the House objected and dropped it in conference.

Maybe that was a wise thing to do in view of what happened with the crime bill. They said, "Let us save it for the health care debate." So we have saved it for a year and a half now. We may not finish this debate this year. Hopefully, we will. But we have already lost an opportunity to get some of that $100 billion a year that we are losing. We are losing $275 million a day—$275 million a day—to fraud, $11.5 million every hour to fraud. Yet, we have delayed almost 2 years now from taking any action to deal with it.

Mr. President, the key principles agreed to in the Republican health care task force were also contained in the bill submitted by Senator CHAFEE on behalf of some 20 of us who supported his efforts.

They are also contained in many of the Democratic proposals. Indeed, they are even contained in the latest version of the majority leader's amendment. Many of these principles were incorporated into Senator Lloyd Bentsen's proposal that was passed in the Senate—but later dropped in conference—as part of the 1992 tax bill.

So we had broad bipartisan support for those new initiatives.

In the fall of 1992, Senator DOLE, Senator CHAFEE, I, and several others, approached the majority with a list of what we called 11 points of commonality between Republican and Democratic proposals. We met with the majority leader's task force on more than one occasion to press for these reforms on which there was broad-based bipartisan agreement. These were significant steps that we believed could and should be taken immediately to slow the growth of health care costs and increase access to quality health care for millions of Americans.

We were rebuffed. We were told that reforms were not comprehensive enough and that anything short of comprehensive reform would not do.

Mr. President, let me say, very frankly, it was a stall. It was a stonewall. I believe it was a political tactic to delay any reforms until the elections were over in November. That is what happened. The Democratic majority wanted a perfect issue and not an imperfect solution, and it was a perfect political issue at that time. The point is, we had broad-based agreement and we could have passed something.

So here we are, 2 years later, still talking about the same principles on which we know there is broad-based bipartisan agreement: portability, no preexisting condition exclusions, affordable coverage, expanded access, emphasis on prevention, cost containment, administrative simplification, and stronger efforts to combat fraud and abuse.

We agree on those provisions, and they are part of the Dole-Packwood bill. They are also part of the Mitchell bill.

The problem is the majority leader's bill goes far beyond these areas of agreement and would drastically alter the delivery of health care in this country.

I have listened to the debate, and I must tell you I have been moved by the recitation of the tragic stories that have affected and have afflicted so many thousands and perhaps millions of Americans who lack adequate health insurance coverage under the current system. I cannot agree more that we must do everything we can to correct this situation for the families who are suffering on a daily basis.

But what is most tragic of all is that most of the situations that have been so poignantly described in this Chamber during the portions of the past 4 days that have been devoted to the health care debate would have been helped immediately by the proposals

set forth by Senator CHAFEE, myself, and others.

Mr. President, health care reform has often been compared to two other major social reforms of the 20th century—the creation of Social Security in 1935 and then Medicare some 30 years later. However controversial they may have been at the time, both of these major proposals were ultimately passed. The House passed the Social Security Act by a vote of 371 to 33, the Senate by a vote of 77 to 6. The margin on the Medicare bill was somewhat narrower but still conclusive—68 to 21 in the Senate, and 307 to 116 in the House. As controversial as they were, these two measures enjoyed broad bipartisan support.

We are told that the President of the United States is now pursuing a 51-vote strategy. Let me suggest that it may—and I will talk about this at length in a moment—it may be in the political interest of the President to pursue that strategy. I think it is bad for the country. Let me just suggest why.

If we are to pursue a 51-vote strategy in this Chamber, or 52 votes or perhaps even 1 or 2 more, I can assure you that the very next thing that is going to happen after the election in the fall is that the reforms we pass now will begin to unravel.

In the fall elections, we on the Republican side expect to gain several more votes. It may be one; it may be two. Conceivably it could be 10. I do not want to alarm the chairman of the Finance Committee—let me compromise—let me say that we expect that anywhere from one to five may come to our side.

In any event, whatever the margin of increase, I can almost assure you that, from the day we come back into session next January, an effort will be made to undo legislation that passed by a 51-vote strategy. And the President will sit in the White House and he will exercise his veto, and, depending upon how many Members are added to this side of the aisle, he may be successful. He will spend the next 2 years of his administration vetoing legislation.

In the meantime, the country will be in a state of complete turbulence. Our constituents will want to know: Are we in? Are we out? Do we have a plan or not? Is it HIPC or non-HIPC? Is it voluntary or involuntary? What should we plan on?

I can guarantee you the effort will be made on this side to undo something that passes by that narrow a margin. That is not good for the country.

We need not do that. We have an opportunity to put together something that many of us, if not most of us, can support.

But if you are just looking to have 51 votes, and that is it, on a straight, narrow party line vote, you will get a short-term political victory, perhaps—and I am not even sure it will work in the short term to the President's advantage. It may be that it only causes more turbulence in the country prior to November, and it will not redound to his benefit or to anyone else's in this Chamber.

Mr. President, I have a profound sense of apprehension about any strategy that seeks to ram something this important through on a party line basis because there are people of good will on both sides. There are many good things in the Mitchell amendment, and there are many good things in the Dole-Packwood proposal as well.

The decisions we make in the coming weeks will have profound consequences for every single American and will control the future direction of one-seventh of our Nation's economy. We should not even begin to contemplate enacting such sweeping reforms unless they have broad based and bipartisan support.

To date, much of the discussion of Senator MITCHELL's plan has focused on the issues of universal coverage, mandates, and the search for the ever-elusive perfect trigger—what some have called the Goldilocks trigger, one that is not too hard and one that is not too soft.

Mr. President, Gertrude Stein once said, "A rose is a rose is a rose."

An employer mandate is still the equivalent of a tax on jobs, with a trigger or without. Whether you call it a mandate, it is a tax by any other name.

Employers are not going to bear the cost of that insurance—workers will, in the form of lower wages, lost benefits, and lost jobs. And CBO's analysis confirms that fact.

The trigger does nothing to change the essential problems with mandates. It just delays their impact until after the turn of the century. It is a slow-burning fuse that will trigger long-term damage and the loss of thousands of jobs.

Further, all of the focus on mandates and triggers has clouded the much more important issues that have to be decided with regard to what we are proposing to do with the health care system in the interim.

Even without the mandate, there is considerable new regulation in the majority leader's bill. This regulation will not only undermine the most effective and time-proven cost containment mechanism—competition—but it is going to add significantly to the costs of running a small business.

I am not sure those of us in this body appreciate the regulatory burdens that small businesses already face. I have the benefit of a private adviser on these matters. He is my father. He is 85 years old. He works 18 hours a day, 6 days a week. He has no pension plan. He has no investments, no stocks, no bonds. He just has to keep working to support himself and my mother and other members of the family. I know what he has to go through to make ends meet. And he could not do it, he could not stay in business if we imposed a mandate, as the Gephardt bill will do, upon him. It may be the majority leader's amendment's exclusion of employers with 25 or fewer workers will exempt him or others similarly situated.

But once you have a mandate in place, it is only a question of time until it starts to be applied along the line. We will have to deal with the arguments that a small business exemption allows employers with less than 25 workers to cost shift. One can see inevitably that the handwriting on the wall is not forgery. It will ultimately be applied down the line to every single employer.

Another person whose counsel I have taken and would urge others to take on this matter is, surprisingly, that of former Senator George McGovern.

Two years ago, Senator McGovern had printed in the Wall Street Journal what amounted to a mea culpa. He regretted that he never really understood the struggles of running a small business until after he left public service and opened a small inn in Connecticut.

He wished he had this experience before he entered the Senate. He said that he would have been a better Senator and a better Presidential contender. He said he would have been more sensitive to the impact Government mandates and regulations have on small businesses, driving up operating costs and even—as in his case—forcing many of them into bankruptcy.

Mr. President, I ask unanimous consent to have printed at the end of my remarks the article written by Senator McGovern for the RECORD.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

(See exhibit 1.)

Mr. COHEN. Mr. President, as CBO has repeatedly testified and reported to us, no one really knows what the impact of the regulations contained in this amendment are going to be—no one, not the Members of this Chamber, not the other Chamber, not the country, not CBO. No one knows the impact of these regulations, and we ought to proceed with some caution.

I recall a few years ago when Congress instituted a tax on luxury boats.

The chairman of the Finance Committee is nodding.

It was perceived by many simply as a way of squeezing revenue from the rich and the famous. Instead they stopped buying large boats and the workers suffered. We aimed at the wallets of the rich and we hit the blue-collar, middle-class workers in the neck. We put them out of work. We put them out of work because we were trying to tax the rich. "Let's get the rich," we said, and we hit the people right in the middle.

And this legislation runs the risk of hitting those same people right in the middle by putting them out of work as well.

This is a very good example of how Congress often does not appreciate the ultimate consequences of its actions. We ought to keep this in mind as we continue to debate health care legislation.

One of the clear messages that I have received from my constituents is they are concerned about choice, about any plan that takes too much of the decision-making authority about health care out of their hands and puts it into the hands of the Government regulators or bureaucrats.

The majority leader's legislation creates dozens and dozens of new Federal and State bureaucracies that would have unprecedented authority to regulate the way health care is bought, sold and, to a certain extent, even practiced in this country.

We have a powerful new National Health Board that would be making decisions on what medical care is necessary and appropriate—decisions that one would think should be between the patient and his or her physician. A National Council on Graduate Medical Education will set quotas and tell medical students what specialties they can practice. And there is a strange system of mandatory voluntary purchasing cooperatives that is going to herd all employees of businesses that have less than 500 workers into large collectives and destroy their employers' ability to control their costs.

All of this focus has dismissed concerns about costs.

Mr. MOYNIHAN. Will the Senator yield?

Mr. COHEN. I am almost finished. At the end, I will yield.

Now, a key element of cost containment has to be more competition. The more regulated the health care industry becomes, the less competition can occur and the more costs are going to increase.

One of the best ways to control health care costs is to give consumers incentives to choose efficient, cost-conscious plans. However, the majority leader's legislation would impose a complex and convoluted tax on plans whose premiums are growing—no matter how low those premiums might be.

This would lock in existing price differences, penalize plans that have been efficient, and reward plans that are not. It is little more than a backdoor approach to price controls.

Finally, I am concerned that the so-called fail-safe mechanism in this bill—which is intended to ensure that health care reform does not add to the deficit—is too weak. It is almost certain that the spending associated with the new entitlements and subsidies in the bill are going to exceed all expectations and further fuel the deficit that threatens to cripple the economy right now.

And I might point out that when Medicare was first adopted, it was projected to cost, I believe, $500 to $600 million. Lyndon Johnson said, "That is something that we can afford," and we passed it. The cost of Medicare now runs—correct me, Mr. Chairman, if I am wrong—as high as $150 billion per year.

So again we have to exercise some caution when we are projecting what ultimately will be the impact of legislation that we are proposing.

A few days ago, I had lunch with my oldest son, who was recently married. He said to me during lunch, "I hope that Congress will pass something by the end of the year." He will soon be off to graduate school at Dartmouth. He said it would be helpful, he thought, to have a health care bill that we could pass this year.

I assured him that I hoped it was possible. I would like to see legislation passed. But he, like most of my constituents, has no idea what devils lurk in the details of this massive amendment. He has no concept. And, indeed, the Members of this Senate still have limited knowledge and comprehension of what is in here.

There is a group of us meeting as I speak, 15—I think yesterday it reached as high as 17—Members of the Senate who are sitting down, going through this bill page by page, line by line, all individuals who are highly intelligent, who have studied this for several years, and who are confused about the implications of what is contained here.

We are working today. We will start again on Monday. We will continue to work through all next week so we can at least make some constructive proposals in terms of how we think this legislation can be improved.

I also pointed out to my son that the proposal that President Clinton now supports—namely, the majority leader's proposal; and the bill that Mrs. Clinton now opposes, namely the majority leader's proposal—is likely to raise the insurance rates that he and others in his age group will pay in order to reduce the costs to older citizens.

Frankly, he was stunned. He was absolutely stunned. He had no idea that pure or flat community rating would cause such an increase in his own insurance rates, which he cannot even afford now.

There are other provisions in this bill which are likely to stun the American people upon their full disclosure. And, Mr. President, at a future time, I will have more extensive comments to make when we debate these specific provisions of the majority leader's bill.

I would like, in the meantime, to add my own comments of praise to those of Senator CHAFEE for the majority leader, and commend him for modifying the President's proposal in an effort to seek compromise.

The next few weeks give us a very narrow window of opportunity to enact meaningful health care reform legislation. I suggest that the principles—the key principles outlined at the beginning of my statement—could form the basis of a centrist reform bill that relies upon competition rather than Government regulation to control costs, expand choice, and to ensure that everyone has access to the health care they need.

I believe it is the kind of proposal that would attract the broad-based, bipartisan support that is necessary for health care reform to succeed, and it would take us in the direction I believe the American people want to go.

I resist the notion that has been articulated by the White House that it is the majority leader's bill or nothing. If that is the case, we may very well end up with nothing. I have been encouraged by my colleague from Maine and his statement that his proposal is just the beginning and that he welcomes constructive proposals to improve it. And that is the attitude with which I have spent the last 3 years, nearly 4 years, of my own life in this body, working to improve our current system.

Finally, Mr. President, let me say that President Clinton and Mrs. Clinton have, I think, justifiably complained about the negativity that seems to be pervasive in our society. I think that they have been, in many instances, unfairly criticized. I think that they have taken a lot of unneeded, unwarranted, unjustified assaults. This is something that all of us should struggle to overcome and try to do our best to eliminate from our proceedings.

But it also works in the same fashion for them. They cannot, in turn, point to individual Members of the Senate, Senator DOLE in particular, and try to demonize him, saying: "There; the Republican leader is seeking to delay, to impede, to destroy."

Senator DOLE, not alone in this Chamber, but perhaps more than any other individual, has suffered pain during his lifetime. He knows what health care means and what not having it means. He can tell you—and he will not tell you—from family history what it means to go without insurance, to go out and have to raise money to pay for treatment that is not available without it.

So I do not think anyone is in a position to be too pious and point their finger at Senator DOLE or anyone else in this Chamber in an attempt to undermine their motive or cast aspersions upon their character.

What we need to do is to continue a debate which is healthy, constructive, positive, and has respect for all the Members in this Chamber.

There are others who also suffered war wounds and other types of pain

during their lifetime. And no one, be it in this Chamber, the other Chamber, or in the White House, ought to be pointing fingers at those who are seeking to come up with the best possible proposal for the American people.

Mr. President, I hope there will be a cease-fire, a white flag raised, no more ad hominem attacks on individual Members. I think there is good will in this Chamber and that we can work together to come up with something that the majority can support and the majority of the people of this country will rally behind.

I yield the floor.

EXHIBIT 1

[From the Wall Street Journal, June 1992]

A POLITICIAN'S DREAM IS A BUSINESSMAN'S NIGHTMARE

(By George McGovern)

Wisdom too often never comes, and so one ought not to reject it merely because it comes late.—Justice Felix Frankfurter

It's been 11 years since I left the U.S. Senate, after serving 24 years in high public office. After leaving a career in politics, I devoted much of my time to public lectures that took me into every state in the union and much of Europe, Asia, the Middle East and Latin America.

In 1988, I invested most of the earnings from this lecture circuit acquiring the leasehold on Connecticut's Stratford Inn. Hotels, inns, and restaurants have always held a special fascination for me. The Stratford Inn promised the realization of a longtime dream to own a combination hotel, restaurant and public conference facility—complete with an experienced manager and staff.

In retrospect, I wish I had known more about the hazards and difficulties of such a business, especially during a recession of the kind that hit New England just as I was acquiring the inn's 43-year leasehold. I also wish that during the years I was in public office, I had had this firsthand experience about the difficulties business people face every day. That knowledge would have made me a better U.S. senator and a more understanding presidential contender.

Today we are much closer to a general acknowledgment that government must encourage business to expand and grow. Bill Clinton, Paul Tsongas, Bob Kerrey and others have, I believe, changed the debate of our party. We intuitively know that to create job opportunities we need entrepreneurs who will risk their capital against an expected payoff. Too often, however, public policy does not consider whether we are choking off those opportunities.

My own business perspective has been limited to that small hotel and restaurant in Stratford, Conn., with an especially difficult lease and a severe recession. But my business associates and I also lived with federal, state and local rules that were all passed with the objective of helping employees, protecting the environment, raising tax dollars for schools, protecting our customers from fire hazards, etc. While I never have doubted the worthiness of any of these goals, the concept that most often eludes legislators is: "Can we make consumers pay the higher prices for the increased operating costs that accompany public regulation and government reporting requirements with reams of red tape." It is a simple concern that is nonetheless often ignored by legislators.

For example, the papers today are filled with stories about businesses dropping health coverage for employees. We provided a substantial package for our staff at the Stratford Inn. However, were we operating today, those costs would exceed $150,000 a year for health care on top of salaries and other benefits. There would have been no reasonable way for us to absorb or pass on these costs.

Some of the escalation in the cost of health care is attributed to patients suing doctors. While one cannot assess the merit of all these claims, I've also witnessed firsthand the explosion in blame-shifting and scapegoating for every negative experience in life.

Today, despite bankruptcy, we are still dealing with litigation from individuals who fell in or near our restaurant. Despite these injuries, not every misstep is the fault of someone else. Not every such incident should be viewed as a lawsuit instead of an unfortunate accident. And while the business owner may prevail in the end, the endless exposure to frivolous claims and high legal fees is frightening.

Our Connecticut hotel, along with many others, went bankrupt for a variety of reasons, the general economy in the Northeast being a significant cause. But that reason masks the variety of other challenges we faced that drive operating costs and financing charges beyond what a small business can handle.

It is clear that some businesses have products that can be priced at almost any level. The price of raw materials (e.g., steel and glass) and life-saving drugs and medical care are not easily substituted by consumers. It is only competition or anti-trust that tempers price increases. Consumers may delay purchases, but they have little choice when faced with higher prices.

In services, however, consumers do have a choice when faced with higher prices. You may have to stay in a hotel while on vacation, but you can stay fewer days. You can eat in restaurants fewer times per month, or forgo a number of services from car washes to shoeshines. Every such decision eventually results in job losses for someone. And often these are the people without the skills to help themselves—the people I've spent a lifetime trying to help.

In short, "one-size-fits-all" rules for business ignore the reality of the marketplace. And setting thresholds for regulatory guidelines at artificial levels—e.g., 50 employees or more, $500,000 in sales—takes no account of other realities, such as profit margins, labor intensive vs. capital intensive businesses, and local market economics.

The problem we face as legislators is: Where do we set the bar so that it is not too high to clear? I don't have the answer. I do know that we need to start raising these questions more often.

The PRESIDING OFFICER (Mr. MATHEWS). The Senator from New York.

Mr. MOYNIHAN. Mr. President, could I congratulate and thank the Senator from Maine for his remarks and tell him that there is much more I agree with than disagree? But the central point of what he has said is how much in common we have on both sides of the aisle. I would remind him that the Committee on Finance reported a bipartisan bill and that bipartisanship is still here. On the front page of the New York Times—that is my hometown—Mr. Adam Clymer this morning reports, "Mitchell Sees Room for Dealing on Rival Health Care Proposals." "Big Gain Toward a Compromise in the Senate."

Mr. Mitchell, the majority leader, said today that issues raised by bipartisan moderates led by Senator John H. Chafee appeared to be negotiable.

And of course they are.

I think we all need to ask ourselves about this particular form of ineffectiveness, of almost an entropic decline in our capacity to produce results, whether it is institutional, systemic—I do not know. Twenty-five years ago a Republican President—we can say that now—proposed a guaranteed income, which twice passed the U.S. House of Representatives and died in the Senate from those who said it was too much and those who said it was too little and those who made the calculation that, my goodness, if a Republican will do this, think what the next Democrat will do.

That same Republican President proposed universal health care and employer mandate. And I am standing 3 feet from the Republican manager of the bill here, Senator PACKWOOD, who introduced it. And again the calculation was made. Some thought it was too much. But on our side, some said not enough, we can get more. Think; if that man would give us this, think of how much more we can get. And we got nothing. That is the record. We got nothing. It is a quarter century of impasse.

And I think it is only in the spirit of which he speaks that we will move on. Because we are not getting better in some respects. I have frequently spoken of the extraordinary advances in medicine—medical technology, medical science—that we have seen in the last 30 years. But on the subject of infant mortality, in 1960 the United States was 11th among 23 OECD countries in infant mortality, and 30 years go by and we are 21st. We have not been looking to our affairs very competently. And we continually miss these opportunities.

There is an element of the neurotic in this, an element of the individual who repeatedly states one desire and behaves in a way that thwarts that desire. It is a very common neurotic pattern. I do not have to tell a person of the insight into these matters of the Senator from Maine, but I thank him for his address.

Mr. COHEN. Will the Senator yield at this point?

Mr. MOYNIHAN. I yield the floor.

Mr. COHEN. Mr. President, I go back to what I think will be the problem. Articles have been written about "demosclerosis." That our democracy has become——

Mr. MOYNIHAN. Demosclerosis.

Mr. COHEN. Filled with special interest groups that are highly organized; that they will prevent not only attempts to adopt new legislation but

prevent any modification of existing legislation. We are suffering from a sclerotic condition.

One of the reasons I feel so strongly about not pursuing this 51-vote strategy, or narrow, partisan strategy, is that what will take place in the country, if the country sees that we are divided virtually on party lines with some minor exceptions, they will then be divided along party lines as well. Our division will be replicated and reflected out in the country. And they, in turn, will mobilize forces to change what we have done. That will continue. I am persuaded that will continue into the future.

If we really want to do something constructive for the country, if we reach broad-based bipartisan support, we send the signal to the country that we are united. If the country and the groups that are out there feel we are divided, as we are today—publicly at least—in terms of these issues they will seek to exploit that. And, year after year, President Clinton—he will not enjoy the next 2 years, I can assure you. He will not enjoy the next 2 years. We will not enjoy the next 2 years. And the country will be in a state of confusion.

I am pleading for both sides to try to find some appropriate middle ground. I am part of the Chafee mainstream group. I have been so. I continue to work in that fashion. I just hope we can stop the attacks. Frankly, I think by going to the amendment—I understand what the strategy is: Let us go to the amendments. Let us get some momentum going, pass some amendments, and give at least the perception that we are doing something constructive, rolling along. And that will give the House the incentive to go ahead.

We are in a situation where we, for the first time, are proceeding on a major tax bill in front of the House because they do not want to go first now, something extraordinary in our history.

I understand the tactics involved. But I plead with my colleagues on the other side, do not believe Members over here are seeking to stall and delay for the purpose of stalling and delaying. There are people over here who have been working on this for years, who would like the opportunity to speak. I have waited 4 years to speak—what was it, 25 minutes? I only consumed 25 minutes. I wanted to make that speech before we got to the amendment stage. There are others who feel equally strongly.

So I just resent the notion that somehow the headline story is Senate Republicans impede progress on health care legislation. We are not seeking to impede. We would like an opportunity to explain our positions to our constituents, to inform them of what we believe to be some of the deficiencies in the proposals, to let them know that a number of us over here, and I would say Senator DOLE is in this category—he has encouraged us to see if we can come up with some constructive solutions.

So it ought not to be labeled obstructionist once again, and pure negativity on the part of the Republican Party. I think we are working to see if we can do something that is in the best interests of the country.

Mr. KENNEDY. Will the Senator yield for a question?

The PRESIDING OFFICER. Who yields time?

Mr. MOYNIHAN. Let me, when Senator KENNEDY speaks, yield our time.

Mr. KENNEDY. I was listening—and I see others who want to address it. But as we are moving through the course of the debate, I think it is important that we try to find out, as we use these terms, how they are related to the legislation that is at hand. I know there was some question in the presentation of the Senator about the allocations of various residency programs. Of course the Senator understands that the American taxpayers pay for better than half of all the residencies, unlike the law schools where individuals pay or the law schools pay.

So there are those, of whom I am one, who think since the American taxpayer is paying half or even more in many situations across the country, that the idea that the public should have some interest in the percent of residencies in different kinds of areas is not all that radical. Particularly when the AAMC, which is the principal instrument for the medical colleges, supported various—this proposal.

I was wondering, since the Senator mentioned this in what I perceived as somewhat of a derogatory way about the Federal Government making decisions about who are going to be doctors and specialists, what does the Senator—what is the Senator's alternative?

Mr. COHEN. I ask whether or not the Senator from Massachusetts thinks it is in the best interests of the people of the State of New York to tell the State of New York how many orthopedic surgeons it might plan on?

Mr. KENNEDY. Of course that is not in the bill. That is not in the bill, in terms of allocating any kind of formula to any particular medical school. I know there have been those who have been out here for the past days who suggested that, but that is not the bill.

The other point I would make to the Senator and that is on the preexisting conditions. I was just looking through the Dole legislation on preexisting. We are all against preexisting conditions as well. It is in the Mitchell bill. Those provisions are illustrated in the Dole proposal on page 80 where it talks about the preexisting.

I do not question in my own mind that the Senator wants to eliminate preexisting conditions. We have been listening to debate on both sides saying how we all want to eliminate preexisting conditions. Of course, the Dole provision does not provide that. If you have any kind of serious illness, serious sickness, if you have diabetes, if you have cancer, if you have been diagnosed in those particular ways, you are excluded under the Dole proposal.

I am just wondering, as the Senator and the chairman of the Finance Committee has pointed out, in a spirit of comity, if the Senator's position would be whatever we pass will truly eliminate all preexisting conditions, in whatever will be coming through hopefully—prayerfully. I think, quite frankly, there are some provisions in terms of the complete elimination of the preexisting under the Mitchell proposal that might be adjusted to change as well.

But just in terms of where the Senator from Maine is coming out, do I understand he would be for the complete elimination of the preexisting condition and would like to see that changed in the Dole bill or perhaps modified in the Mitchell bill?

Mr. COHEN. I believe that there is quite a similarity between the Mitchell proposal and the Dole proposal, as far as preexisting condition. My own view—I go back to my personal view—is, I favor the elimination of preexisting conditions with perhaps some timeframe to make sure people do not wait until they actually get sick before seeking coverage. I think you will find broad-based support in the Chafee proposal, and I think the Dole proposal is not that far away from the Mitchell proposal on preexisting.

Mr. KENNEDY. There are other Senators waiting.

If you have heart disease today, if you have cancer today, if you have diabetes, juvenile diabetes, under the Dole proposal they are not considered to be eligible, under the language that is printed in there. I will join with the Senator in working to make sure, however, that as we come through this process that we do it.

I certainly know that the Senator—I have talked to him about health care policy on a number of occasions—his own position is the elimination certainly, and mine. And it is one, I think, as we go through this discussion and debate, it is important because I think that is one of the very, very important key items in terms of any health care policy reform: The elimination of that preexisting condition. We can talk about it. The real question, as has been pointed out by our colleagues, is whether the language conforms.

Mr. COHEN. May I say in response, that is one of the benefits of taking our time and going through the legislation so we are all sure exactly where the Mitchell bill is, where the Dole bill is, where the Chafee proposal may take

us. That is the benefit of having this kind of debate without characterizing it as being obstructionist or anyone trying to engage in a filibuster. I have not heard anyone—virtually no one—on this side talk about a filibuster. We want to discuss this measure at length because it is not altogether clear what the distinctions are between the legislative proposals.

I might say, Mr. President, if I can just complete my remarks, it seems to me there is a philosophical approach that is quite different in how we have approached it and how those on your side have approached it.

I believe Senator MITCHELL takes the position, and that is reflected by the majority and Democratic side, that you must have universal coverage in order to reduce costs. Those on this side take the approach that we must reduce costs in order to get universal coverage. Hopefully, these two positions will move closer together. But those are the basic philosophical differences that divide us right now. I believe there is a middle course we can pursue to achieve our goal.

Mr. KENNEDY. If I can ask one final question. When you talk about the cost provisions in the Dole bill, as the Senators——

The PRESIDING OFFICER. Who yields time?

Mr. MOYNIHAN. I yield as much time as the Senator needs.

Mr. KENNEDY. There are other Senators here.

In looking through this—and I think this is another element in terms of the limitations on costs—I had a good deal of difficulty in identifying on page 82—it basically talks about rating limitations for community-rated plans. There is no limit on how much insurance companies can charge.

We have seen since 1986 that there has been a 117 percent increase in premiums with only a 24 percent increase in wages. We have seen the flow lines. Perhaps the Senator—maybe others on that side—as we go through the day can address that issue. I think it would be helpful. I think we are getting into the substance of preexisting conditions, the children's issues, how are we going to get a handle on costs.

I, quite frankly, think we are going to have to address the issues, at least for me perhaps, even more effectively than we have in the Mitchell bill. In looking through that, I do find that it is difficult to see where the costs would really be restrained in the Dole proposal.

Mr. MOYNIHAN addressed the Chair.

The PRESIDING OFFICER. The Senator from New York.

Mr. MOYNIHAN. Mr. President, I want to associate myself with the Senator from Maine with respect to what is in this bill.

Several days ago, a week ago, I offered the thought that it would be most unwise for the Federal Government to start lowering the number of medical graduates who were taking their residency in our hospitals. It would reduce the supply of doctors. It was agreed that this was not to be done, as I understood.

Yet, I open to page 483, "Health Professions Workforce and Public Health Initiatives, Workforce Priorities Under Federal Payments."

We turn here, Mr. President, and we find that we apparently have established a National Council on Graduate Medical Education. It says—the Senator from Maine might want to hear this—on page 491:

ANNUAL AUTHORIZATION OF NUMBER OF POSITIONS.—In the case of each medical specialty, the National Council shall * * * designate for academic year 1998–1999 and each subsequent academic year the number of individuals nationwide who are authorized to be enrolled in eligible programs in each medical speciality. * * *

(b)(1) REQUIREMENT ACROSS SPECIALITIES.—

(B) REDUCTION.—For each of the academic years * * * total determined * * * shall be reduced by a percentage determined by the National Council.

If I may say, Mr. President, this is not my understanding of how science proceeds. I claim no special knowledge of this at all. But I have been a member of the President's Science Advisory Council. I have been a vice president elected to the American Association for the Advancement of Science, the largest organization of its kind in the world.

I feel scientists would recoil at the notion that work which is, by definition, unpredictable and follows extraordinary paths, collapses one discipline into another and then expands in five more—that sort of creative process—for the Government to reach out and require, but most importantly, to reduce.

Do we want fewer doctors in order that there be better health? This has never been debated, never been explained. It just keeps coming out in this legislation. There is a staff member somewhere who wants this. And no matter what we do, we keep getting it.

This is hubristic. This invites the wrath of the gods. This invites the death, the closing of a great moment of medical discovery, unprecedented on Earth. In the history of medicine, no such thing has happened in the advances in the last 30 years made in the United States. This is, if I may say—and I do not wish to introduce first amendment problems to this debate—but this is a sin against the Holy Ghost.

Mr. COHEN. If the Senator will yield——

Mr. MOYNIHAN. I have said all I have to say. I have to go back in the back room and read this again.

Mr. COHEN. I am told that the members of the Finance Committee, the so-called mainstream group that reported out the bill in the Finance Committee, when they saw the actual language of the bill, were stunned; that they found there were measures put in the bill that the committee reported out that there was complete disagreement upon. And the attitude was, well—staff's attitude was, well, since you did not discuss it, we had no prohibition against putting it in. We had members coming out and saying, well, I supported that bill—what I thought was the bill—but I do not support this legislation any longer; that is not what we thought we had agreed upon. Am I incorrect in that?

Mr. MOYNIHAN. I must say there is a staffer somewhere—not on the Finance Committee staff—who does dearly love quotas for thoracic surgeons. How he got that way, or she got that way, I do not know. But we are on the verge of adopting them and we will not know we have done so.

Mr. ROCKEFELLER addressed the Chair.

Mr. MOYNIHAN. Mr. President, I yield the floor. I see the Senator from South Dakota was going to speak but the Senator from West Virginia wants to speak on this point.

The PRESIDING OFFICER. The Senator from West Virginia.

Mr. ROCKEFELLER. I thank the distinguished Presiding Officer.

I thought the Senator from Maine just at the very end of his remarks brought up an extremely important point, and I think it is in fact the core of this whole debate. That is, he said that what the Democrats appear to want to do is to do universal coverage in order that you can reduce cost, and what the Republicans want to do, to the extent that there are differences, what the Republicans want to do is reduce cost and then proceed to universal coverage.

That takes me back to precisely the first subject that was discussed and debated in the Pepper Commission. Senator DAVID DURENBERGER was a member of that Commission. Senator EDWARD KENNEDY was a member of that commission. BOB KERREY was not a member but attended all of the Commission meetings.

And that is the core of the debate. We debated that on our very first series of meetings. They always began at 8 o'clock in the morning. What we decided was that you cannot pick one core or pick the other core, you have to do both at the same time to achieve both or other; that if you do not go for universal coverage in the Mitchell plan, it is not an immediate reach—it is a step-by-step reach—that you can by definition not control costs.

On the other hand, if you just simply control costs, or in the Dole plan, for example, as you cut from Medicaid and Medicare and things of that sort and do not return those into programs for seniors but for subsidies for the poor, that

is not going to get you universal coverage.

We decided on a bipartisan basis—there was not a single dissenting vote in the group—at the beginning of the Pepper Commission, as we set our basic philosophy, we agreed that we had to do both. We had to work for universal coverage, which we achieved in our plan, and cost containment, which in my judgment we achieved but achieved insufficiently in our plan.

I agree with the Senator. I think that is fundamental, and I would lay down that stipulation as a major source of meritorious, substantive debate in these next several weeks. We have to do both, Mr. President. We have to both work toward universal coverage and we have to control cost if we are going to make the American health care system work.

I thank the Chair.

The PRESIDING OFFICER (Mrs. MURRAY). Who yields time?

Mr. MOYNIHAN. Madam President, the distinguished Senator from South Dakota, the chairman of the Democratic Policy Committee, is on the floor equipped with diagrams, and I yield him such time as he may require.

Mr. PACKWOOD. Madam President, would the Senator yield for a unanimous consent request?

Mr. DASCHLE. I would be happy to yield.

Mr. PACKWOOD. I ask unanimous consent that Peter J. Levin, a fellow on health care on Senator MACK's staff, be granted floor privileges during the consideration of S. 2357, the Health Security Act.

The PRESIDING OFFICER. Is there objection? The Chair hears none, and it is so ordered.

Mr. PACKWOOD. I thank my friend from South Dakota.

The PRESIDING OFFICER. The Senator from South Dakota.

Mr. DASCHLE. Mr. President, I, too, want to express my strong agreement with some of the points raised by the Senator from Maine just a moment ago.

He, like many of us, has expressed an interest in bipartisanship and trying to reach agreement on many of these difficult points. He indicated he, too, was concerned about the mischaracterization of much of what is being proposed here. He expressed his concern about impugning motives on the Republican leader, and I share that concern.

Like the Senator from Maine, I have immense respect for the Republican leader, as I know he has respect for the Democratic majority leader. Yet, I hear many remarks made on both sides of the aisle that mischaracterize his proposal and use hyperbole to make points.

Last night, as we ended the debate, there were many references made to the Mitchell bill. In fact, if they were just references, I would not be troubled. But many opponents of the Mitchell bill raised what they characterized as three versions of a Mitchell bill. They want us to believe that, somehow, the majority leader, using all of his imagination and legislative prowess, has come up with not one but three versions of his own bill.

That troubles me, frankly, because it is this type of mischaracterization, as the Senator from Maine correctly stated, that undermines our ability to have a substantive discussion of the real issues. Obviously, as concerned as I am with complexity and the need for a better understanding of what it is we are talking about, I asked the majority leader what was the basis for the changes made. His answer was surprising.

All of the changes in the version being characterized as a completely new bill are on one page. This is it. These are all the changes in the Mitchell bill—one page.

This legislation is a melding of the Labor Committee and Finance Committee bills. We have known that from the beginning. So no one should be misled into thinking we are redrafting the entire health care reform proposal and coming up with new versions daily.

The Republican manager of the bill, our colleague from Oregon, is probably as experienced a legislator as we have in the Senate. He has had to manage bills. He, like all of us, understands that as you develop legislation, there are technical corrections and other changes that must be made. He has had to do that himself on countless occasions. And so it makes a nice prop, but in my view it is a mischaracterization of what is going on here. And as the Senator from Maine so ably stated it, it does not serve the Senate or serve those who may be trying to understand this debate to imply that we have completely different versions coming out each day.

I think what is really important to the American people, what is important to this country, what is important to this body, is simply to try to do what we know has to be done. That is what we are here for, to address our health care problems.

I know, as the Senator from Maine also suggested, there are differences in philosophy. He cited one that I think is a very fundamental difference, though I do not think that it is necessarily a partisan difference.

I have a mentor who is no longer with us, who used to admonish the partisanship that often comes in heated debate and cautioned me on many occasions early in my public career not to view debates as Republican and Democrat, but as constructive and destructive. Oftentimes the debate becomes destructive for short-term political gain when, through constructive analysis and constructive debate, we can better realize our common goals.

One of those constructive debates that I hope will occur is how we do achieve the goals that we say we all want. We talk about universal coverage, and we talk about effective cost containment. And as the Senator from Maine implied, there are those who believe that you cannot achieve universal coverage until you have effectively controlled costs.

I believe, Mr. President, it is just the opposite; that until we include everybody in the system, we cannot effectively control costs. So many of the experts who came before the Finance Committee reiterated that point and elaborated on why it is important. All one has to do is think of an emergency room today. What happens when a person is not covered today? What happens is that person comes into an emergency room for what may be a bottle of aspirin costing somewhere between $2 or $3 in a pharmacy. But that trip to the emergency room for a bottle of aspirin for a young child with a fever costs $75. That is the kind of proliferation in costs that we are trying to deal with.

If that person walking into an emergency room had comprehensive insurance coverage, they would not have had to go to the emergency room. They would have been able to go to the pharmacy and get whatever pain relief may be required without exponentially increasing the cost of that one visit. That is how universal coverage affects cost containment. That is what we are talking about.

If people cannot get primary and preventive care, their costs are much higher in the long run. But it is not just running up the costs in a linear fashion. You also cost shift those costs. There are administrative costs involved in trying to figure out who is going to pay. Will it be the Government? Will it be the insurance companies? Will it be the hospital absorbing those costs? Somebody must cover those costs. That cost shift is what we are talking about.

Madam President, we will have many opportunities to debate these very consequential points. But I hope that, as the Senator from Maine suggested, we can do it with civility, that we can do it without impugning motives of those who may disagree with us.

As we have indicated, there is a profound admiration for many of those on the other side of the aisle who have studied this issue and who have come to different conclusions than some of us have on important points.

I hope that, as we try to resolve those differences, we can do so keeping in mind the best interests of this country and the credibility of the Senate.

Mr. REID. Will the Senator yield?

Mr. DASCHLE. I am happy to yield to the Senator from Nevada.

Mr. REID. I note the Senator indicated that the cost of emergency room

treatment for someone needing aspirin is $75. I would say to my friend from South Dakota that may be the case in South Dakota, but in Las Vegas or Reno that same treatment would be closer to $300. That is going to the emergency room in Las Vegas, especially Las Vegas, and in Reno to a lesser degree. And the emergency rooms are filled with people who have no other place to go for health care. It may be a bad sore throat or a broken leg. But the fact is most of the people are there as a result of not of an emergency, not because of a motorcycle accident, but because they are sick and have no other place to go.

Mr. DASCHLE. The Senator makes a very important point. Obviously, the costs vary as you cross the country. Emergency room care is high-technology care involving extraordinarily high costs. In concentrated areas like Las Vegas, they are even higher than they are in rural settings like we have in South Dakota. So $75 may actually be the minimum charge for that kind of care. You could spend as much as $1,000 or $2,000 for emergency care, hundreds of times more than care provided in a traditional outpatient settings.

So I think the Senator makes a very important point. I was conservative with my $75 estimate. It could be much more.

Mr. REID. I would also say to my friend from South Dakota that I have followed this debate very closely. During the first days that we were working on this, our friends from the other side of the aisle rose and spoke on the Mitchell bill in a negative fashion.

Now, with the other bill that has been introduced, and we have stood to critique that bill, suddenly, it is no longer the way to do business here. We should not look at what is inside the Dole bill. Let us not look at the fact that it does not do anything for small business. Let us not look at the fact that it really is not a universal coverage bill. Let us not look at the fact that it does nothing for children or pregnant women.

I say to my friend from South Dakota that I think that is a responsibility we have, not in a mean-spirited fashion, but in an effort to find out what is in the Dole bill. I think we have a responsibility to do that, especially in light of the fact that the majority leader took considerable time before his bill was introduced. He took what he felt was the best out of finance bill, what he felt was best out of the education and labor bill, the best that he found in other plans that have been proposed by the mainstream group and others.

So, I think during the next few days and weeks, if it is necessary, we have to take a look at the bill that is being talked about as being the bill that is going to take care of health care in this country, and that is, namely, the bill offered by the distinguished minority leader. Does the Senator from South Dakota agree that we should take a look at that?

Mr. DASCHLE. Absolutely. I think the Senator from Nevada again makes another point that we ought to recognize. The purpose of this debate is to analyze the different approaches pending before the Senate so that we can come to some conclusions about which is the most appropriate course of action. I think that is the whole purpose of having a good, healthy debate about the different options available to us. We hope to do that again in a civil way, in a way that recognizes differences in philosophy and approach, but also recognizes the consequences of making the most appropriate decision.

The reason I have always felt the majority leader's bill was so critical to us is that, frankly, it does what we have said all along must be done if we are going to achieve meaningful reform and provide health care for all Americans. At the end of this process, we must accomplish our primary goals—offering greater choice, controlling costs, putting emphasis as the Dodd amendment does, on good primary and preventive care, especially for pregnant mothers and children, and providing opportunities for higher quality care.

In South Dakota these are all very serious concerns. How do we achieve good quality? How do we achieve meaningful cost containment? How do we achieve greater emphasis on primary and preventive care? How do we get universal coverage? The Mitchell bill makes a substantial contribution to that goal by melding the Labor and Finance Committee bills, which have been developed over many, many months.

Mr. KENNEDY. Will the Senator yield for a question? As the Senator mentioned, the melding together of the two different committee bills—is the Senator familiar with the fact that actually in the Labor Committee we had 51 hearings on health care since the introduction of the President's bill and a markup, and Finance held 30 hearings from September to June 1994. So those are 81 days of hearings with good representation of the Senate on that which has been included.

Mr. DASCHLE. I think the Senator is absolutely right. There has been an incredible amount of debate and analyses in both the Labor Committee and the Finance Committee. I know the Senator from West Virginia has held many hearings in the Veterans' Committee to explore how veterans would fare under health reform.

We have listened to witnesses from across the country—frankly, from all over the world; we have had people from other countries who have come to Washington to share their concerns and their experience with us.

Our colleague from Oregon has been a significant participant in those hearings. I do not know that he has missed a hearing. That demonstrates the kind of interest, the kind of thoughtful study that has gone into the process so far.

Mr. KENNEDY. Can I ask a question in one other area of public policy?

Mr. DASCHLE. Yes.

Mr. KENNEDY. I know the Senator has been interested in this. We were talking earlier today about the difference between the Mitchell bill and the Dole bill and how it treats preexisting conditions. I would just like to ask whether my understanding of the difference between the two bills is accurate—which is enormously important to families all over this country. There are about 44 million Americans who have some disability, and the 87 million American families have been touched by it. As I understand it—and correct me if I am wrong—under the Dole provision, if you are treated for an illness or a sickness anytime prior to the 3 months before you have an application or get your insurance, then the preexisting condition will not be treated for the next 6 months, will be excluded. As I understand it, that is the position of the Dole bill.

On the other hand, on the Mitchell bill, you have what is called the amnesty provision, so that anyone who has a preexisting condition can be covered. During the first enrollment time, the exclusion of preexisting conditions is waived, if it is the first time. Second, if that individual is receiving any kind of subsidy, which means that they are moderate-income working families, then that exclusion of preexisting conditions is waived, and the bottom line is that by the year 2000 all of it is eliminated, all preexisting conditions, as barring participation in the insurance program.

I am just asking the Senator if that is his understanding, because as we were talking before during the course of the debate, we are finding out many people are using these words: "We are for universality, cost containment, elimination of preexisting condition," but when it comes down to it, we are going to find out what is going to be in the different legislations. On the one hand, under Mitchell, by the year 2000, preexisting conditions are eliminated; and, second, if you have the subsidy, the preexisting condition is effectively eliminated. Third, for the first-time enrollment period, after this bill goes into law, it is a clean deck, an amnesty. You have those three protections for individuals.

I daresay I am sure the Senator would wish, as I do, that the day the bill is passed, we would have what exists in the Mitchell bill for the year 2000. Nonetheless, we are making a commitment to all Americans that may have heart disease, cancer, diabetes, juvenile diabetes, or may have had

any range of health care needs, that those preexisting conditions are going to be out. On the other hand, I have difficulty in finding in the Dole bill any of these kinds of protections. And the one that I have stated—that is, if you have been treated for the 3 months prior to the time you are in, you are excluded for any kind of additional treatment for 6 months. Generally speaking, that is a time when you need help the most, because you have lost your job, because you are not able to perform your work, and you are going to be hard pressed.

That is something that I just ask the Senator, whether he agrees with me, and if that is his understanding of the difference; and second, if he agrees with me that it is a major, major difference between the approach of the majority leader and the minority leader.

Mr. DASCHLE. Madam President, I think the Senator characterized the bills accurately. In fact, I think that is exactly why we have the situation we have now with regard to the two bills. There have been many references made to the length of this bill—1,400 pages. Some reference was made to the fact that the Dole bill is a lot smaller. Well, it is half the size because it does half as much.

One of the most important things that it leaves out, in my view, is the very issue that the Senator from Massachusetts raises. If there is anybody who ought to be concerned about what we do in health reform, it ought to be those today with preexisting conditions. Most are hard-working American people, and they are the ones who would give almost anything to have greater access to doctors, hospitals, and insurance plans, but they are locked out and they and often their children have no access to health insurance.

So what happens, obviously is that the costs go up for them, for the system, for everybody involved. That is really one of the most important distinctions I would draw between the two bills.

We have to be able to say at the end of the day that we have addressed the concerns of all Americans with preexisting conditions. We cannot leave them out. The majority leader's bill does address their concerns, and I think that is one of the most important differences that ought to be recognized in this debate.

I yield to the Senator from Nevada.

Mr. REID. Senator DOLE's plan limits but does not eliminate preexisting conditions. Under the Dole plan, insurance companies would still be able to deny coverage for preexisting conditions for up to 1 year. That is section 21–111 of his bill. While most universal coverage plans use preexisting condition limitations as a necessary transition to them before universal coverage is reached, the Dole bill never achieves universal coverage. It never even comes close. Thus, there is no reason to believe the exclusion in the Dole bill, as indicated by the Senator from Massachusetts, will ever go away.

If I could ask the Senator from Massachusetts—if I can get the attention of the Senator from Massachusetts. We talk about preexisting conditions, and I think the American public thinks of someone in very, very bad shape, almost ready to die, like a heart attack or having cancer. But the fact of the matter is—I am asking the Senator if he agrees—preexisting conditions could be a skin problem. Someone may have had a skin cancer on their face, or they could have orthopedic problems and they are denied coverage.

Is the Senator familiar with cases like that?

Mr. KENNEDY. The Senator is absolutely correct. In so many of these instances, as we have heard in the course of those hearings, you have individuals who may have had a heart attack. And I can think of one woman in Belchertown, MA, Kathy Wojnar, who had worked in a vineyard in California, had a heart attack, then moved back to Massachusetts. She wants to work, but she not only cannot get work, but she cannot get any health insurance, either—and she would be glad to participate and glad to pay, and she has a pretty good prognosis. All of us would hope for her for the future. But she has worked all of her life, and she wants to work. She told us that she cannot get a job, because no one will hire her with her health condition.

Those are real-life stories. It is not only her circumstances, but scores of others, as the Senator has described.

Mr. DASCHLE. That is the point I think we need to constantly keep in mind. There are human faces behind all of this, and human experiences that go beyond statistics and reports and testimony.

Obviously, the Senator from Nevada is as sensitive as anybody in the Chamber to those faces and to the extraordinary implications of failure to act.

Madam President, I know that our time in this round is drawing near. I know the Senator from Illinois has a very important matter to which she must attend, and we have agreed here on the floor that she could utilize the remainder of our time in this round subject, of course, to the managers' agreement.

Mr. MOYNIHAN. So everyone will be clear, we do not have rounds. We just have 7 hours, equally divided. We would like to alternate, as we would do normally. But the Senator from Indiana graciously suggested that the Senator from Illinois might want to speak now as she has a very pleasant family duty to attend.

So I yield to the Senator such time as she may desire.

Ms. MOSELEY-BRAUN. Madam President, I thank very much the Senator from New York, the Senator from South Dakota, and Senator PACKWOOD, for their courtesy.

I mentioned earlier that the Senator from New York was kind enough 2 days ago to mention my son's 17th birthday, and it was the first time in 17 years that I was not with him on his birthday because we were here, engaged in this historic debate.

Madam President, I would like to share a story with you briefly, as I talk about health care reform in a context that to me makes all the difference and why this is so important. When I decided to run for the U.S. Senate, I had a conversation with my son Mathew, who was then 15, who said to me: "You know, Mom, your generation has left this world worse off than you found it."

That was like a body blow to me at the time. Of course, I disputed him about that. I said to him: "You are wrong. My generation does this and this."

For everything I had to say to him, he had a response as I guess one would expect from a 15-year-old who knows everything.

In any event, when I got here I made a point to take a look at some long-term issues that Mathew referenced in our conversation over dinner that night.

So following last year's budget debate, I asked and was appointed to serve on the President's Bipartisan Commission on Entitlement and Tax Reform. Just last week, that Commission issued its findings on the long-term trends this country is facing. Let me just talk about a couple of those findings in the context of health care reform.

Finding No. 1 states, that by the year 2012, "unless appropriate policy changes are made in the interim, projected policy outlays for entitlements and interest on the national debt will consume all tax revenues collected by the Federal Government" all by the year 2012.

It goes on to say that, by the year 2030, "unless appropriate policy changes are made in the interim, projected spending for Medicare, Medicaid, Social Security, and Federal employee retirement programs alone will consume all tax revenues collected by the Federal Government."

That finding also estimates that "if all other Federal programs (except interest on the national debt) grow no faster than the economy, total Federal outlays would exceed 37 percent of the economy. Today, outlays are 22 percent of the economy, and revenues are 19 percent."

Finding No. 4—and this is important with regard to this debate—goes into the trends in health care expenses. It states that "the growth of public and private health care costs poses an immediate problem that must be addressed."

It goes on to state that "Federal health care spending has been increasing at annual rates averaging 10 percent or more during the last 5 years, far in excess of overall economic growth. Private sector health costs have increased comparably."

Now, Madam President, I would like at some later point in this debate to go further in detail about why health care costs are rising so high and why they are so far outstripping the growth in our economy.

We have a chart which shows even if we control health care inflation, Federal health care spending doubles by the year 2030.

There are other charts in this regard—and again I will, at another time when there is more time, discuss the cost implications of the rising explosion in health care spending, address them.

However, Madam President, there has been a lot of discussion in the context of the health care reform debate about partisanship. I have to tell you that the findings of the Entitlement Commission are entirely bipartisan. The Commission's membership includes 12 Members of the Senate, 6 Democrats and 6 Republicans, and 10 Members of the House of Representatives, 5 Democrats and 5 Republicans. All but one of these Members voted for the findings I just quoted to you, because they are facts that we absolutely have to face up to.

It seems to me that in this debate that is the most important thing that we can do, to face up to the economic facts. The Entitlement Commission was formed because Congress and the President recognized that the current trends are not sustainable, and the only way to address those trends in a way that avoids imposing real pain on large numbers of real people is to act now.

Without action on comprehensive health care reform, without action to restrain the growth of private health care costs as well as public health care costs, the American people, including 85 percent of the American people who have health insurance now, face a future of less and less access to medical care, of higher and higher costs out of their own pocket, and of greater and greater risk of losing their health insurance altogether.

Madam President, let us make no mistake about the importance of this debate. Inaction will not protect Americans access to high-quality, affordable health care. In fact, just the opposite is true. Inaction will virtually guarantee that the access of most, if not all, Americans to high quality, affordable health care will be eroded and ultimately lost.

Again, I call you back to the conversation with Matthew. His perception at the time was actually supported by the findings of the Entitlement Commission, and that is why it is absolutely imperative that we move and do something specific about this issue now.

So, Madam President, if we are to keep a health care system of which we are justifiably proud, and I think it is fair to say that America has the greatest health care system in the world, if you can afford it and access it, if we are to keep a good quality health care system, if we are to keep health care affordable and available for the 85 percent of our population who now has insurance, and if we are to deal with the 15 percent of our population who does not now have insurance, if we are to reduce that figure, even if we simply want to keep it from growing dramatically, we must face our health care problems and face the long-term health care costs trends, we must act.

I would be the last one to say that the Mitchell bill represents the be all and the end all in terms of an answer to these cost trend problems. It is not. The cost controls in the bill can and need to be strengthened, in my opinion. The Mitchell bill, however, does represent a solid start in the right direction to put us on the road to achieving the goals that the Entitlement Commission spoke of. We need to work on it in a bipartisan way. We need to work with colleagues on both sides of the aisle to achieve the goals that are so important to rein in the growth in costs in health care and to preserve the kind of quality system that I believe we have.

We are right now in the midst of a historic debate, and I know everyone who has spoken to this issue has talked about that. Many believed that this time would not come. I listened to conversations and debate referencing all the years of trial and error in this regard.

Just in this session of the Congress, the Finance and Labor Committees of the Senate have held over 100 hearings on health care reform and, as Senator MITCHELL said the other day, President Truman proposed reform in 1940's, President Nixon proposed reform in the 1970's, and 50 years is not rushing anything. I agree it is an enormous task and a complicated one, but quite frankly that is what we were elected to do, to tackle enormous problems and to answer complicated questions.

We hear continually from people back home that they are happy with the health care and they are afraid of reform. They do not know what all this means. I would submit that quite frankly what we are dealing with in that regard is what I call the 1,000 points of fright. There has been an awful lot of misinformation out there about what is going on, and frankly, it stands to reason that you will have misinformation where there is complication. You always have people putting out road blocks and diversions and side tracks when you are on the road to genuine change.

But let me say this: I believe that we can achieve that change. I believe that that change is imminent if we work together in the best interest of the country to preserve a quality health care system and to address the long-term trends that the Entitlement Commission spoke of.

Madam President, from the beginning of this debate, I have referenced what I call the four cornerstones of reform, and those four cornerstones of reforms are universal coverage, which is so important I believe, cost containment, maintaining the quality of care, and retaining freedom of choice for the American people in terms of the health care delivery and the providers of health care.

I believe we can achieve those four cornerstones if we approach this debate in a bipartisan way, if we approach this debate with the view to the long-term trend, as well as a view to all that affects us not only in the global macroeconomic sense because it has this kind of implication, but also in the personal sense, how it affects people where they live, what actually is going on in the world of people who need health care.

I recently received a letter, Madam President, from a constituent that described her family's experience in obtaining insurance. The Pascals are self-employed people and they have three healthy children. Over the past 8 years they have been forced to change insurance carriers six times. The first company increased the rates on their individual family policy by 600 percent in a 5-year period.

Finding the cost of that plan prohibitive, the Pascals joined a group plan in order to lower their costs. Unfortunately, the group was dropped because one of the members of that group got sick. The family then moved back to an individual policy, but due to a 65-percent rate increase after the first year, they could not afford that any longer either. So in desperation they settled on a catastrophic coverage plan that has no preventive care in it, that requires a $5,000 deductible and that limits the providers they can go to.

So now the Pascals find themselves in the situation where they can no longer take their children to the pediatrician.

And that, it seems to me, is outrageous. This family has done everything right, they have even managed not to get sick, but affordable, comprehensive health care coverage is still beyond their reach.

Clearly, our system should not work this way, not for the self-employed and not for the employed with employer provided coverage.

Statistics indicate however that over half of employed Americans who receive coverage from their employer have had their health benefits cut back

or had their employee contributions increased during the last 2 years.

No wonder, Madam President, a recent poll said that 60 percent of the American people were still worried about losing their current coverage.

Madam President, I used the Pascals as an example. I am sure we will hear and have heard many, many more individual stories. But the fact of the matter is that this system really is broke. It is not working for ordinary people. It is not working for working people.

It is something of an anomaly that we now have a system in which the very wealthy can have health coverage, the very poor can have health coverage, and everybody in the middle is worried about it, either they cannot access it or afford it because they are self-employed or in job lock because they cannot leave because of a preexisting condition or, alternatively, the cost of the health care that the employers are providing is going up and up and up, millions of Americans like the Pascal family cannot afford insurance. Our Government cannot afford it. Our Nation cannot afford it. We absolutely have to have an imperative to change.

Last year, our country spent $1 out of every $7 on health care. That amounts to about 14.3 percent of our GDP and a total of $898 billion. And we know, again, health care costs are rising at twice the rate of inflation still. Medicare and Medicaid take up almost a quarter of the entire Federal budget.

And so, we are looking at these escalating costs and wondering what, if anything, we can do.

I believe that we have now a window of opportunity to begin to correct the situation and fix this problem.

As I see it, we now have two options: One is to use the Mitchell bill as a base for building health security for the American people. The other is to use the Dole plan as the basis.

But in any event, we have to, I think, achieve the four cornerstones and we have to build on this bill, or a compromise of the two or a variation of the two, we have to build on what we have introduced here to come up with a plan that gives us universal coverage, that really, genuinely puts us on the road to universal coverage. Because, quite frankly, without it, we will continue with the cost shifting that has escalated the cost of health care in this country.

We have to maintain choice. We have to maintain high-quality care and we have to achieve cost containment. I hope the cost containment imperative of this issue does not get lost in the debate, because that, after all, has implications for the Matthew Brauns, Madam President, for your children, and for these pages sitting here. If they are going to have health care, we have an obligation to fix this nonfunctioning system.

Madam President, I believe the Mitchell bill puts us on the road toward universal coverage. According to CBO, it will reach 95 percent by 1997. And the employer mandate, of course, will result in universal coverage by the year 2002.

I do not think, frankly, the Dole bill achieves that to the same extent. I believe the Mitchell bill, based on my initial reading of it, significantly improves and expands coverage for millions of Americans. All children and pregnant women up to 300 percent of the poverty level will be covered. And that is $44,000, Madam President. That is a pretty elastic range.

Preexisting condition exclusions will be eliminated under the Mitchell bill. Coverage will be portable. In other words, a person can move from job to job and still not lose coverage.

Insurance discrimination based on age and geographic location will be eliminated. I do not believe, again, that Dole bill achieves that.

But I was delighted to hear my colleagues on the other side talking about wanting to work together to try to fine tune and do these things in a bipartisan way to achieve a bipartisan consensus on this issue.

The Mitchell bill also guarantees choice, which was one of my other cornerstones of reform. Every American will have a choice of at least three private insurance plans—fee for service, HMO, or point of service.

The Federal Employee Health Benefits Program, available now to Congress and to most Federal employees, will be available to many more Americans.

The Mitchell bill—and I think this is important, Madam President—will also maintain the high quality of care that we have in this country. Funds will be made available through assessment on premiums for graduate medical education, for biomedical research and for health care services research.

A National Quality Council will be established to keep the goals of high quality in place.

Consumer information and advocacy centers will be created to give people information about health care services and to hear grievances.

Query: Where do you go for a grievance about the way your insurance company treats you today or the health care services that you receive today? That is a step forward in regard to quality.

And the health plans must ensure that enrollees have access to specialty care, which is so important when it is your kid who needs something special that is not within the range of the generally provided services, when your kid has a special condition. That is so important.

The Mitchell plan, I believe, also has included cost containment measures.

Again, I would like to work with the chairman of the Finance Committee and others. We are going to have to strengthen cost containment. I think that is something that has to come out of this debate and I think will come out of this debate.

Madam President, I know everybody wants to speak on this issue. I have been saying for months that the Senate was going to act as a committee of the whole with regard to this important issue and I am sure that that is correct.

The chairman of the Finance Committee has been more than gracious with me. I have more to say. In fact, I have several pages more to stay, but I will not say it right now. I will wait until another more appropriate time in this debate. We will come back and I am sure I will have other opportunities.

But I wanted to thank my colleagues for this opportunity today to say that we owe it to the Mathews of the world to address this issue as Americans—not as Republicans, not as Democrats, not squabbling over every dot and tittle of every line, although the dot and tittles have to be worked out, because, after all, the devil is in the details, is it not?

But the fact is, we have an obligation as Americans to fix this nonfunctioning health care system, to provide coverage to every American, to maintain the high quality of health care that we have in this country, to maintain the opportunity for people to choose, and to get the cost containment that will preserve the future for these young people.

Madam President, I am just so delighted at all the hard work that has gone into this debate. I very much look forward to working with my colleagues in a bipartisan fashion to achieve the goals of this bill.

My assistant just passed me a note which said, "You forgot to speak about the Dodd amendment," which I have more pages on. I will defer until Monday to speak to the Dodd amendment specifically. I will support it. I hope Dodd will add me as a cosponsor of the amendment. I think it is the right direction.

Again, I congratulate my colleagues and thank them for the opportunity to have a few words about this issue.

The PRESIDING OFFICER. Who yields time?

Mr. MOYNIHAN. Madam President, may I simply use this quick occasion to thank the Senator from Illinois for her able and thoughtful remarks and for the emphasis on a bipartisan approach. That is how we are going to get something that we are not only going to enact but is going to stay enacted.

It was a wonderful note on which to get off to that birthday celebration.

I thank the Senator very much.

Madam President, before I yield the floor, I would like to thank the Senator from Indiana for his courtesy.

The PRESIDING OFFICER. Who yields time?

Mr. PACKWOOD. I yield such time as the Senator from Indiana may consume.

The PRESIDING OFFICER. The Senator from Indiana is recognized.

Mr. COATS. Madam President, I thank the Senator from New York for his kind remarks, as well as the assistance that I have received over the last several weeks in trying to understand the health care legislation from the Senator from Oregon.

Madam President, not to be the skunk that spoiled the picnic in this wonderful spirit of bipartisanship this morning—the rhetoric obviously cooled down from where we were last evening.

Let me just comment briefly, before I give my statement, on some of the discourse that has taken place here this morning, because it does relate to the discussion that took place last evening relative to the implication and expressed charge that Republicans were attempting to deny the supporters of the Mitchell plan from moving forward with their bill when I think it is clear that what we are attempting to do is trying to understand the nature and the complexity of the bill that is before us and seeking time to understand what all of this means. Just this morning we have had two differences of opinion relative to what the legislation seeks to propose. One of the Senators from the other side of the aisle indicated that there were no specific quotas as to medical specialties. That was corrected by the Senator from New York when he pointed to page 491 of the bill that is now before us, the Mitchell III bill, which specifically states, in section 3013, under title I: "Annual Authorization of Number of Specialty Positions." Line 16 begins: "In the case of each medical specialty, the national council shall"—not may—"the national council shall designate for academic years 1998–1999, and each subsequent academic year, the number of individuals nationwide who are authorized to be enrolled in eligible programs in each medical specialty."

It then continues on for 16 pages describing how this is going to be applied and setting out specific percentages.

Beginning in 1998 and 1999 it says: "The percentage of the graduating class that completes the eligibility programs in primary care shall not be less than 39 percent; in 1999–2000, 44 percent; then in 2000–2001, 49 percent; then academic year 2001–2002, 55 percent."

It is interesting to note there is a requirement in here for a study of the impact of this, but that study is not due until January 1, 2005. So the decision, obviously, has been made without the understanding of Senators, as was indicated on the floor by the Senator from New York. The decision has been made to go forward with a quota system designating which specialties are eligible under this program. And then after it is implemented, we will have a study back to us in the year 2005.

It is this type of confusion, it is this type of mandate that exists throughout this entire 1,433-page piece of legislation that is precisely why many of us believe that we need to take our time, to analyze what is here, to analyze what it is this bill seeks to accomplish and what implications it is going to have, not only on our health care system but our economy as a whole and on all 250 million Americans that will be subjected to the provisions of this act.

We have struggled this week to understand what this bill purports to accomplish. We were delivered a copy of the original Mitchell bill. In fact, many outside organizations delivered pieces of paper to our office asking Members to pledge to read the entire bill before they vote on it. They said it is not fair to impose on all of us as Americans a new health care system unless you, the Representatives and Senators, understand what is in it and read it. I signed that pledge and I began reading the original Mitchell bill, only to be surprised that a second bill was then brought before us. I was part way through a massive tome, weighing 14 pounds, trying to understand the complexity of it and cross-referencing all the sections and then I was suddenly given a new 14-pound bill, "By the way we have made some changes."

The Senator from North Dakota said, "Those changes just fall on one page. It is unfair to imply that the Mitchell II bill, which is of the same size, is a completely new bill." In that respect he is correct, partially correct, because it is not a completely new bill. But that so-called "one page of changes" simply lists the titles that are changed and the sections that are changed. I point out that the changes are comprehensive, and take extensive cross-referencing and understanding to see what changes have been made.

In title I alone, 33 sections were changed. That means we have to check every one of those sections to see what the change is.

In title II, six sections were changed as well as subtitle D.

In title III, 27 sections were changed as well as subpart B of part 3 of subtitle D, and on and on it goes. The entire subtitle A changed of title VIII, subtitle B of title IX, and of title XI it says: "all." So in title XI it is all changed. Which means we have to discard title XI in the original bill, pick up title XI in the second bill and attempt to understand the difference.

This relates back to the question of the quotas under medical specialties, because it says here in title III that section 3012 is changed. Section 3012 is what I just quoted from; 3012 and 3013 is all part of subpart B, Authorized Positions in Specialty Training.

So this is the difficulty that we face. That is why we simply are asking for time to review and analyze the bill and understand the bill and understand its implications. What we learned this morning is that the floor manager of the Mitchell bill, the chairman of the Finance Committee, arguably the individual in this Senate body who knows more about health care than any of the rest of us, was astonished to find that this bill, indeed, despite what he thought were the Finance Committee recommendations to the staff, that this bill indeed includes a 16-page section authorizing specialties.

If that is a discovery to the chairman of the Finance Committee, who knows more about health care than anybody else in this body, you can imagine what that says to a relatively new Member of Congress who does not serve on that committee relative to what may or may not be in this bill. I think that is all the more reason why Members need to read and understand and staff needs to analyze exactly what it is we have before us in this legislation and why there should not be a rush to finish or move legislation in this body. We are up against a time pressure. Members have had to cancel plans with their families, cancel plans with their children who will be going back to school very shortly. The thought is we need to move ahead and get this thing out of here, we will put the finishing touches on it later, so we get at least some semblance of a break.

But we are dealing here with perhaps the most important piece of legislation that this body may have ever dealt with. It certainly has more implications for our economy and obviously more implications for our health care system—which encompasses one-seventh of that economy—than any other piece of legislation that we have ever faced. That is why we feel it is important to take some time to understand what it is we are dealing with and make sure we have a right to be heard, each and every Senator, on our sentiments regarding this bill.

I would also like to correct another misimpression that has been left. That is that the only Members of the Senate or of Congress who have a vision of health care for America—or who care about this issue—are supporters of the Mitchell bill or the Kennedy bill or the Clinton bill. The Republicans simply want to stop all changes, stop all reform. They are just simply naysayers who have no health care thoughts of their own. I think that implication is wrong.

As the Senator from Maine [Mr. COHEN], eloquently outlined this morning, he has been a proponent of health care reform for a number of years, even devised his own plan—even submitted his own legislation—and has been actively working, as many of us have, for a number of years to try to grasp what is going on in health care, to try to understand what changes need to be made and should be made to make it a more

efficient system and more accessible to all Americans; and try to bring about those reforms which will preserve what is arguably and, I think, demonstrably the most effective health care system in the world, that provides more quality care to more people than any other system; to retain the benefits of that system, to retain what is good about that system and make reforms and fix those areas that are wrong.

Republicans have offered a variety of plans. Senator NICKLES offered a comprehensive plan. Senator GRAMM has offered a plan which I collaborated on and which incorporated the concept of medical savings accounts—which I will talk about in a moment—which I think truly goes to cost containment and may be perhaps the only concept that truly affects, in the longrun, effective cost containment.

We have had the Lott-Michel bill. We have had a number of other proposals floating around here from Republicans who are sincerely interested in making changes. Senator CHAFEE has spent years working with a group in proposing legislation. Senator PACKWOOD and Senator DOLE now have a plan on the floor before us.

So the implication that Republicans do not care, that Republicans just simply want to say no to anything, that we are just simply out to submarine and torpedo the President, no matter what is proposed for health care, that implication is wrong. I think those who have followed the issue know that it is wrong.

When I came to the Senate in 1989 and tried to evaluate the issues that we would be dealing with during my time here, at the top of the list was health care reform. I told my staff: "This is going to be a major—if not the major—domestic issue of the nineties that the Senate will have to grasp and have to deal with, and I don't feel I am prepared to deal with that. I think I need to do a lot of homework and we, as a staff, need to do a lot of homework." I employed people who had an understanding and knowledge of the health care system, and they have worked diligently to try to incorporate ideas and gather information and bring me up to speed on what is happening in health care.

I have traveled the State of Indiana visiting hospitals and emergency rooms and outpatient clinics, visiting community health centers and migrant health centers, talking with doctors and nurses and physical therapists, and ambulance drivers and patients and recipients of health care. I have visited nursing homes. I have held town forums and health care meetings, I have brought in experts, all in an attempt to understand this massive health care system that exists in the United States, and understand what might be right with it and what might be wrong with it.

Out of that effort, we produced a piece called "A Hoosier Model for Health Care Reform." This was published in 1990. It conceptually discusses what this Senator believes are the major problems in health care, and proposes solutions to those problems. It is a model based on my experience in Indiana and based on the experience of a number of health care providers and consumers in Indiana.

I will just read the table of contents to show how it addresses what I think are some of the concerns that have been raised here:

The Coats health care plan confronts the fear of rising costs; section 2, How the Coats plan confronts the fear of rising costs; 3, How the Coats plan confronts the fear of losing coverage; 4, Supplements to the Coats plan, women, children, seniors and fighting disease.

It incorporates the models of the medical savings account, which I referenced just a few moments ago, as a cost containment measure and an innovative way of providing health care incentives for individuals to become actual consumers of health care.

So that it is not a third party making a decision about who pays the bill and how much that bill will be, but the actual beneficiary of the health care is an active participant in determining the cost of health care.

It is interesting that in this country, we shop, we are consumers for just about every product and every service in America. We would not think of going to the car lot to buy a new car without checking down the street or across town with a competitor to see if we could get a better deal. We would not think of buying a television simply by picking up the phone and saying, "Just send me a 35-inch, I don't care what it costs."

But in health care, the question is not is there a more cost-effective way I can receive the benefits of health care; is there an alternative treatment that will not cost as much; can I get the same drug or the same diagnostic procedure or the same treatment somewhere else for a better price? Those questions are never asked.

The only question asked is: Is it covered by my insurance? And if the answer is yes, it is covered by my insurance, then we do not care who provides it or how much it costs.

The medical savings account is a way of putting that decision in the hands of an individual. I will just give one brief example of how it works.

A woman in Indianapolis called me and said, "I finally understand the genius of the medical savings account." She said, "I have reached the age where it is important that I get an annual mammography, a mammogram." She said, "I called up the local hospital and said I would like to schedule a mammogram, how much does it cost?"

They said, "$250."

She said, "Wow, that seems like an awful lot of money." She said, "Do you guys ever have sales?"

And they said, "Well, no, we don't have sales, but we offer, in the week preceding Mother's Day every year as a special attraction to women to encourage them to get a mammogram, we offer it for $50 during that week before Mother's Day."

She said, "Sign me up." She said, "It suddenly dawned on me that if someone else is paying the bill, I don't care whether I get it in March or May, or whether it costs $50 or $250. But if I am paying the bill and I stand to benefit and save by getting the same procedure for a better price, then I'm going to look and shop for that procedure at an effective price." She said, "I would have saved $200 had I been a consumer under a medical savings account."

Medical savings account simply says that as an employer or individual, you can choose to go outside of employment and protect yourself with a catastrophic policy, protect yourself from the excess medical costs that can take away a lifetime of savings or run someone into bankruptcy.

So you buy a policy that covers all expenses over $3,000, and you take the $3,000 that you normally would have put into purchasing an insurance policy and you put it in an account in your name, just like an IRA, except this is an MSA, medical savings account, instead of an individual retirement account.

That medical savings account is in your name and your family's name, and it can be used for the first $3,000 of medical expenses. To the extent you do not spend it on medical expenses that year, that savings rolls over tax free and accumulates toward retirement. It can be used then to purchase a long-term care policy, it can be used to supplement Medicare or a number of other medical purposes.

To the extent that you use all that $3,000, you kick into the catastrophic coverage policy and that covers all your extra expenses. So the employee or the individual is not out any more money. They simply are spending it in a different way. But the difference is that they have a personal incentive to be cost conscious in terms of purchase of health care. It is the only way that I have discovered that truly will affect human behavior which will truly affect health care costs.

Right now about 10 percent of Americans, I think, eat shredded wheat without sugar on it in the morning, or some kind of fiber cereal which tastes like oats that you give to the horses. They choke it down every morning because it is good for their health. The rest of us are into all this sugar stuff that dominates the shelves, and so forth. Ten percent of us, I think for altruistic reasons, say I am going to do what is good for my health—eat right, exercise, so forth.

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I met with one of the Nation's leading cardiologists. He said, "You know, Senator, 90 percent of the patients that come into my office are there because of bad choices that they have made. They are either overweight or underexercised, or they smoke too much or they drink too much or they engage in behavior that ends up giving them heart problems." Ninety percent.

As I said, about 10 percent of us will do those things necessary to substantially reduce the risk. Some of this is obviously genetic and some of it is just a fact of life with which we need to live. But most of us will not exercise the discipline because there is no financial incentive to do so.

But it is amazing how Americans respond to financial incentives. It is amazing how we can change behavior when it affects our pocketbook, when it affects the amount of disposable income we have.

A medical savings account provides that incentive. It seems to me, if we truly are going to get at health care costs in this country, we have to provide a means, a way for people to become consumers of health care.

Now, is this the answer to all the health care cost problems? No. It is simply one of the answers because this is an incredibly complex problem. I tried to outline some of that in this proposal that I issued in 1990. But it at least ought to be incorporated as an option, an option for employers and an option for individuals. I am pleased that I brought this idea to Washington. It was incorporated—it is the heart of the Gramm health care plan. It was incorporated in the Nickles plan. It was incorporated now in the Dole-Packwood plan as an option, as a way to help reduce health care costs and give us a more sensible health care spending provision in this legislation.

Unfortunately, it was not incorporated in any of the Democrat plans. It is not part of the Mitchell plan. It is not in the Gephardt plan. It was not in the President's plan. It was not in the Kennedy plan.

In fact, I may be mistaken there. I think we did incorporate it in the Kennedy plan in committee, but it is not part of the plan that is before us.

I also outlined in here the Indiana experience with medical malpractice. I do not know what the total figure is. Many estimate it at $25 to $30 billion a year of unnecessary medical expenses because doctors are ordering tests and conducting procedures and increasing and inflating their charges solely because it is—not because it is in the best interests of the patient but because their lawyer comes into the office and says, "Unless you do this you are going to find yourself in court."

Exercising your best medical judgment today is not enough. This is a litigious society. And there is a substantial portion of the legal profession that makes their living on filing lawsuits and settling them out of court, and you are a prime target because you are in a high-income area.

There are all kinds of gray areas in terms of judgment, in terms of diagnosis and treatment. The medical practice is not an exact science. It is still an art. Even though much of it is a science, it is still an art in terms of establishing the correct diagnosis and prescribing the right treatment. Obviously, human beings are involved and mistakes are made. Those mistakes ought to be paid for and ought to be covered.

What we have found in the malpractice area today is that about 70-some percent of the awards are not going to the patient who is injured but they are going to lawyers or going to the courts. So Indiana, more than 20 years ago, under our then Governor, Dr. Otis Bowen, who later became Secretary of Health and Human Services, implemented liability reform, and it is a model. Is it a perfect model? Probably not. Can it be improved on? I am sure it can, on a Federal basis. But that model ought to be incorporated because we are expending billions and billions, tens of billions of dollars on health care costs that are unnecessary simply because doctors are practicing defensive medicine, because they fear that they will end up in court under a lawsuit that in many cases are not suits that are grounded in negligence that ought to result in needed payments to individuals.

I can talk at length. When we get to that section of the bill, I will. I do not mean to take up time on it.

So the question before us is not whether or not Republicans care or Republicans have ideas or Republicans think there should not be solutions to health care. We have proposed solutions, and many of them I think are innovative solutions and we are disappointed they are not a part of the legislation before us.

But what divides us here, the real issue, is simply this: Can we find solutions to the problems that plague America's health care delivery system today without fundamentally changing the basic nature of a health care system which is, I believe, unarguably the best system in the world and that has provided the best quality care to citizens of any country anywhere in the world? I do not know of any Members of Congress that get on a plane and go to Canada or Sweden or anywhere else in the world for heart surgery or for specialized treatment, or for medical care.

(Mr. WELLSTONE assumed the chair.)

Mr. KENNEDY. Will the Senator yield on that point?

Mr. COATS. I would like to finish my statement, and when I finish my statement I will be happy to yield to the Senator from Massachusetts.

But I know that there are thousands and tens of thousands of people from around the world, who, if they could afford it, would get on a plane and come to the United States. I have a good friend who is a Congressman from upstate New York, from Buffalo, just across the line from Canada. He said, "Our number one industry in Buffalo is the provision of health care services by Americans for Canadians. They stream across the border because they do not want to wait for procedures and because they believe that the health care system in the United States gives them a better quality."

The basic nature of our system is that we as Americans have the freedom to choose our own doctors, choose our own facilities, choose drugs and methods of treatment. That would be limited under a Government-directed and Government-controlled program. We want to retain the freedom to say, "Doctor, I just don't feel confident that I want to pursue the course you have prescribed. I think I will get a second opinion. I think I will search out treatment somewhere else."

I was driving home the other day, and I heard an advertisement from Johns Hopkins, I think, arguably one of the better, if not one of the best, providers of health care in the Nation and maybe in the world. They were saying if you live in McLean or if you live in Springfield or if you live in Oxon Hill or if you live in Bethesda, or any of the Washington areas, or you live in Washington, DC, why not consider Johns Hopkins as the place to get your medical coverage? Why not consider Johns Hopkins Hospital and Johns Hopkins medical facilities as a place to provide even your primary care? Give us a chance.

That is a freedom that Americans want to retain, the right to seek out a second opinion, the right to go to Massachusetts Hospital or Johns Hopkins or the Mayo Clinic or the Cleveland Clinic or the Bluffton Clinic in Indiana, if they think that they can find a doctor or find a treatment that is going to be better in accord with their concerns about their health care.

I think our system, without a doubt, offers the technological innovations that not only improve the quality of our care, but also help curb health care costs that is unparalleled anywhere in the world. We lead the world in technological innovation. It is one of the things that has driven up our costs, but it has also driven down costs. We need to understand that the innovations that have taken place in health care have been dramatic in terms of reducing costs.

Medical innovation in the United States is a product of the system that we have. I know that the drafters of the Mitchell proposal are well intended, but I can guarantee you under that system many of the decisions in

terms of how dollars are directed for medical research and drug research are going to be politically decided and not decided on the basis of market needs and not decided on the basis of medical needs, because it is an inevitable consequence of a Government involvement, whether it is State or Federal, that the political process will rear its ugly head and make decisions as to how money is directed.

We do that in every other program we are involved in, whether it is building a road or funding a college or equipping a military facility. Hundreds of millions, if not billions of dollars are directed by a political decision based on who sits on what committee, based on who can form a coalition, based on what interest group has the most influence, and oftentimes those decisions are not the correct decisions. The market has a way of sorting that out in a way that the political process never can.

I spent a day out at NIH not too long ago, and I discussed the funding that goes into medical research. I was told confidentially and privately, because they do not want to ruffle any feathers here on Capitol Hill, that hundreds of millions of dollars are misdirected into research projects that are overlapping and duplicative because Congress has dictated that that is where the money ought to be spent, and that is driven by interest groups pounding on our door; the ones that pound hardest and the ones that form the biggest coalitions and the ones that somehow tug our emotions the most are the ones that get the money.

They said we just are begging, we are crying out—we have areas where we think we are on the verge of breakthroughs that will make substantial, dramatic improvements in the health care of Americans. We cannot direct money there because it is directed to another area on the basis of a political decision, and our hands are tied.

That is going to be multiplied by who knows what factor, if we move further from a market-directed system to a Government-directed system? Just in drug therapy alone, we have had some dramatic breakthroughs in the last several years. Today, we are treating patients at costs one-tenth the cost of what the procedure was previously.

In asthma, a study in the use of an anti-asthma drug showed that it reduced trips to the emergency room by 96 percent, and hospital admissions were reduced by 62 percent, saving up to $2,250 per patient. The annual cost of this asthma medicine is $431.

Patients suffering from osteomyelitis, a bone infection, were often hospitalized in the past in order to receive intravenous antibiotic treatments that lasted several weeks. Now we have a new generation of antibiotics that can treat these people at home. A documented study shows that we have saved $6,000 per patient with this.

Bone marrow transplants, cancer, diabetes, depression, heart conditions, on and on it goes—gall bladder. Today we do laparoscopy. Who would not accept laparoscopy treatment to remove a gallstone or to remove a gall bladder rather than the open chest surgery that was formerly necessary, that kept patients hospitalized for a minimum of 6 days, that required a lengthy time of recovery? Today they go in with a little tube with a miniature TV camera in it, making an incision smaller than a pencil—a couple of incisions, one in the arm, and one in the chest.

Who would not rather sit in a bathtub and have ultrasound dissolve a kidney stone than to go through surgery or the extraordinarily painful process of passing a kidney stone? One of my staff members has had kidney stone problems, and he said it is an inconceivable difference between what he used to go through with a kidney stone, facing surgery to remove that stone or facing the excruciating pain of trying to pass that stone. And today he goes and sits in a bathtub for an hour, and they turn it on. It vibrates a little bit, and the stone is dissolved.

That is innovation that we do not want to stifle. That is innovation that can truly affect the health care costs. Is it the total answer? No. But it is a part of the answer that we do not want to stifle. I am afraid that we will stifle that for the reasons that I have stated.

Mr. President, I was reading the other day in the Washington Post—and there were three articles in that paper. I was fascinated by their relationship one to the other, even though it was not intended. The first article is on welfare reform. It described, "Mr. Clinton's $9.3 billion plan to reform the welfare bureaucracy . . . having now admitted welfare's utter failure . . ."

From HHS Secretary Donna Shalala, "There is no magic solution to the complex problem of chronic welfare dependency."

The article described, " . . . because of the difficulties of changing such an enormous bureaucracy."

The "bureaucracy" under the Mitchell health care plan, the Gephardt plan, the Clinton plan, whatever emerges from all of this, the bureaucracy will make the welfare but bureaucracy welcome. It will dwarf the bureaucracy that currently exists in the welfare system. Yet, the Secretary of HHS said, "We cannot change that system because of the bureaucracy." It is so massive they cannot change it.

The second article describes the problems being faced by European governments, and said it finally recognizes that social welfare spending and government-run enterprises do not work.

I quote:

Western European countries are beginning to reshape longstanding economic policy such as cradle-to-grave welfare benefits, and government ownership of businesses presaging far-reaching changes in the way Europeans work and live. The largest economies in Europe are facing unacceptable levels of government debt.

It says * * * unacceptable levels of high unemployment * * * eleven percent of the European union work force unemployment * * * forecast growing difficult in exporting their once prized goods. As a result, governments from Spain to Scandinavia are inching the way from the social democratic policies that have nourished their people and inspired generations of liberal politicians around the world.

Is it not ironic that at a time when Western Europe and socialized medicine and socialized government programs have created unacceptable unemployment in Europe which has created unacceptable costs of goods which are no longer competitive around the world, and when an abysmal future faces those countries which have engaged in what we are about to attempt? Is it not ironic that at a time when they have now concluded that has been a failure we are rushing to duplicate what they have done?

The third article in the Post that day describes the new U.S. Government bureaucracy that would be created under Mr. MITCHELL's plan to nationalize one-seventh of the American economy. Why is it that when all the world's nations, except maybe a couple of exceptions, are dismantling their government-run industries and social welfare bureaucracies in favor of private enterprise when we have recognized that social welfare programs have led not to prosperity but to dependency?

Why is it that we are now undertaking to enact into law a bill that represents the largest Government entitlement program ever devised?

Perhaps, Mr. President, the thing that concerns me the most is not necessarily just the details of this bill but the incredible establishment of bureaucracy that results in implementing the details of this bill. My staff, along with Senator GREGG's staff, spent an extraordinary amount of time putting together a booklet entitled, "A Primer to Clinton-Mitchell Health Care Bill, New Bureaucracies, New Mandates, and New Federal Powers." I did not number the pages—I should have. There are 81 pages. It is a very, very small print booklet. There is no political propaganda in here. It just simply lists item by item the bureaucracies, mandates, and new Federal powers that exist under the bill before us—81 pages, each one itemized and referenced to a section.

So Members can look at this, and then look in the bill and say there it is. There is no commentary in here.

What we found so far are 50 brand-new bureaucracies, 33 powers that run to the National Health Benefits Board, 177 new statements of responsibilities.

The Secretary of Health and Human Services will have under this bill 815 new powers and duties. How many offices is that? How many individuals,

how many outside consultants, how many staff members, how many telephones, how many clerks, and how many lawyers will be needed at HHS to carry out the 815 new powers and duties granted under this legislation?

I have handed these out to Members. I ask them do not just take my word for it. This is not a Republican up here just throwing out some nice political rhetoric. Take the book, check the reference, look in the bill, read about it, and try to understand and grasp the implications of what this would do.

The Secretary of Labor gets 83 new powers, all listed in here. And just today, I have been handed a piece, and I guess I will have to add this. I do not know if I will bring out a coach, too. Maybe we will bring out an addenda sheet of the 49 new responsibilities that will flow to the employer or a plan sponsor—49 new responsibilities. I will get this printed up and have it available for Members on Monday, with reference to the section number so that you can check it out for yourself. Forty-nine new responsibilities that every employer and every plan sponsor in America will have to comply with. Who knows how much that is going to cost and how many new staff positions that will cost. We may see an explosion of employment under this bill, and it will all be Government employment. Maybe that is one of the intended consequences, I am not sure.

The Washington Post said—and it is not a publication, you know, that is necessarily a tool of the Republican Party. The Washington Post said, "The Mitchell bill would create dozens of new Federal and State agencies that would have the untested authority to centralize, reorganize, monitor and enforce the way medical care is being bought, sold, and to a lesser extent practiced in this country. The Mitchell bill substitutes Government bureaucracy for private."

Let me repeat that. The Washington Post concludes, "The Mitchell bill substitutes Government bureaucracy for private. It challenges States and Federal agencies to set up new agencies with complex responsibilities never before performed on the same scale by public or private enterprise. It would require States to enforce complex new insurance industry laws. It obligates States to verify that plans have had the ability to care for patients in the way the law requires, and forces the States to monitor the transfer of billions of dollars in insurance premiums paid by employers and individuals to private insurers."

A wise man once said, "All futures have one virtue: They never look the way that you imagine them." If the bill before us today passes, I do not believe that any of us can imagine what the future will be under this bill, and that is the problem. I do not believe it is a future imagined by the American people, and I believe that is why they are, in overwhelming numbers, calling our offices and writing to us and stopping us at the airport and stopping us on the streets at home and saying, "Do not pass that Government bill."

They do not know the details. We do not know the details. They do not know them for sure, but they have an inherent distrust in the ability of Government to deliver a service efficiently or cost effectively, and they have an inherent understanding that politics will so complicate and so misdirect resources under this bill, that it will become a political nightmare. They simply have lost confidence in the ability of this institution and in the ability of Government to provide services, particularly when it concerns the thing that is the very closest to them—that is, their health and the health of their loved ones. It is one thing for us to argue whether a road should be built north of the city or south of the city, or in Indiana or Ohio; it is another thing to argue whether or not a Government clerk, or bureaucrat, or Member of Congress, or a national health board, is going to decide the health future for your loved ones, your spouse and your children, and whether we are going to layer a bureaucracy on the health care system that we have never seen the likes of in this country.

Mr. President, several months ago, Mrs. Clinton came before the Congress in a joint meeting with the Finance Committee and Labor Committee. It was held over in the Russell Building in that big caucus room over there, a scene of the McCarthy hearings and Watergate hearings, and a scene of some very important battles. The room was filled, and cameras were there, and the press was there. Mrs. Clinton was introducing her bill and touting its virtues.

It occurred to me, as my time to question was coming, that rather than getting into arguing the details of the bill, we ought to at least question the underlying assumptions, the pillars that were the basis for the bill itself. So I raised those questions with her. I said, "Mrs. Clinton, first of all, I understand the prodigious amount of work that you have engaged in while putting this bill together, and your interest in health care." I said, "But it seems to me that it is based on faulty assumptions." I said, "Let me just raise four assumptions with you briefly, and you tell me where I am wrong." I said, "Assumption No. 1, to me, is that the bill is based on the fact that the Government can deliver services more efficiently than the private sector." I said, "Without going into all the details and the long list of examples as to why I do not think that is correct, if you have a package and it absolutely, positively has to be delivered where you want it by the next morning, do you take it to the post office, or UPS, or Federal Express, a private carrier? If it absolutely has to be there for the sale of a house, or the closing of the contract, or the signing of the legal document, or the birthday gift—absolutely has to be there—what do you instinctively do? Do you say I better not take it to the post office? Why? It is a Government-run monopoly, an entity that does not have a very good history of delivering the mail on time."

We learned the other day that there are truckloads of mail that have been sitting outside post offices for weeks and months that have not been delivered, and there is a huge post office scandal. I said, "It seems to me that the underlying assumption that Government can deliver more effectively than the private sector is just not based on experience."

The second assumption is that the Government is more cost-effective than the private sector. I said, "It seems like we cannot pick up the paper in the morning without reading about a new misuse or misapplication of funds, or cost overruns that occur."

Senator GLENN held a hearing in July highlighting some of the Government's inefficiencies. To quote from part of that:

> The Office of Personnel Management found that it needed to make a $54 billion adjustment to its retirement insurance account.

The Internal Revenue Service testified that, well, yes, it might be able to collect $29 billion more in taxes that are owed, but it cannot be sure because the question is, "Why do you not go out and collect it?" They said, "We are not sure that money is owed, but we think it is 29 million dollars." The State Department cannot account for $250 million it paid out.

The Customs Service says it could not account for 10 tons of illegal confiscated drugs.

The defenders of the Clinton-Mitchell plan say, well, you are comparing the post office to health care, and that is like comparing apples to oranges. Let us compare apples to apples. We recently passed and supported a vaccine for children program. The Government is going to buy one-third of the Nation's vaccine supply, package it, house it, and distribute it, starting this October. It is a well-intended program.

The GAO just gave us a report on the progress of that program. Here are the three findings:

The program is way behind in letting purchase contracts.

Two, GAO is unprepared to evaluate whether the system could efficiently process orders from the 70,000 doctors and clinics that are supposed to receive the vaccines.

Three, they are unprepared to adequately test whether the packaging and delivery system would retain vaccine potency. Vaccines require strict temperature controls.

> Our review indicates that it is unlikely that the Government can fully implement

the vaccine for children program by October 1, 1994, and raises questions about whether the vaccine for children program, when fully implemented, can be expected to substantially raise vaccine rates.

If we cannot run a vaccine-for-children program, how are we going to run health care for everything else?

Mr. President, the third assumption that I raised with Mrs. Clinton was: You know, the problem with this is that when you turn things over to Government, politics gets involved instead of the disciplines of the market where, if you do not make a profit, you are out of business and the shareholders are after your neck at the next shareholder business meeting or the stock plummets. Instead of the discipline of the marketplace, the Government does not have a competitor, the Government does not have to make a profit, and the political process always intervenes.

Already, we have seen the interest groups lining up. We have an amendment on the floor now that says—and it is a well-intended amendment, and I take nothing away from its sponsor, who has passionately defended and promoted the rights of children in a whole number of areas, and he cares deeply about that. But already on a political basis we are trying to make decisions that, well, this ought to be included. There are probably 100 areas, 100 items, maybe more, that Members feel just as passionately about for different reasons that they want carved especially in the program, and the decision is going to be made here on the Senate floor rather than in the national health boards or in a commission. It certainly will not be made in the marketplace.

This is not to say that there should not be some of those provisions. This is not to say there should not be a vaccine-for-children program. The question is how can we do this without skewing how the money is allocated, how the resources are allocated? How can we as political entities whose future depends on saying yes and whose career is thought to be terminated when we say no, how can we resist the temptation that we have not resisted, in my experience in Congress, to say, well, maybe we can work that into the next bill. You make a good case. You have an important lobby. That is a touching story. I will talk to the chairman of the Finance Committee to get it in the next tax bill.

Already the litany has started. The Labor Committee added $32 billion of benefits to the President's plan, and when the House Labor Committee took it up, they added benefits. They got a lot of pressure from the dental people, I guess, and they added more. They said they could not draw the line at 18, they had to make dental benefits available to everybody. Some others wanted additional programs for women and children. The mental abuse people are lining up saying, "What do you mean, 30 days? We need 60 days." When they get 60 days, they say they need 90 days of coverage. On and on it goes.

Whatever interest group is not covered right now I guarantee you, if they are not meeting today, they met yesterday, and they are devising their strategy to come and put pressure on us to add benefits and make decisions. We are not the best people to make those decisions. We do not have the expertise. We are politicians.

Everything in us says yes, and we will pay for it later, and if it does not fit, that is OK. You can walk out the door happy. Everything in us says, oh, if we say "no" we are going to have to look for another line of work.

So, I told Mrs. Clinton. I said, it just seems to me that the assumption that we can do this outside of politics undermining your best attempts, undermining the attempts of people who wrote this bill, I just do not think that is within our experience nor see how we can do it.

Her answer to that was kind of disturbing because she said, "Senator, I don't challenge what you have just said in terms of our experience, but I think this time we are going to do it differently."

I just do not believe that is the case.

I know Members are wondering when I am going to quit, and I am just about done. The question, I think, now is, Where do we go from here?

I believe a sensible health care reform bill could be put together on a bipartisan basis in this Chamber in a very short amount of time. We start talking about when Senator Bentsen introduced a bill a few years ago. We talked back and forth. I believe there was majority support for that. It will not solve all the problems, but it will be a huge step forward. It would give us time to analyze progress. It would give us the ability to pay for that progress. It would give us the ability to make changes next year or the following year if we have information back that there is more we could do.

But the President has stated, he has drawn the line in the sand, drawn a couple lines. I was in the Chamber when he said, "See this veto pen. Nothing that is less than 100 percent coverage will get my signature." And that line is now 95 percent. But just the other day he said, "Anything less than the Mitchell bill is totally unacceptable."

Well, we are starting to look at the Mitchell bill, and we already found out that, distressingly, in just one area it is going to set up a Government agency to tell us how many doctors we need in what specialty. Even the chairman of the Finance Committee finds that appalling and unworkable.

Any time we suggest anything less than what the President has outlined, we get nothing but resistance from the White House. So I have concluded that a sensible bill is not going to pass here this year. A bill that is achievable is not going to pass here this year.

I think that only leaves us with one option, and that option is to kill the President's bill, to send a message to the White House, "Mr. President, the American people, as expressed through their representatives in this Congress are not going to support your concept of health care for America."

Until the President gets that message and understands that message, we are not going to make any progress, because he is going to continue to insist that the leadership of the House and the leadership of the Senate pass what he wants. But what he wants has been rejected by the American people. I do not know how many times we have to say this. This thing has been killed six times. Maybe it is like a cat; it has nine lives. We have to kill it three more times. This proposal out of the White House has been dead more times, or thought to be dead more times, than we can count. Yet it keeps trying to resurrect itself.

The President has to understand that his vision of health care for America is not America's vision of health care for America, and unless he understands that, we will not be able to make any changes or any reforms in health care. We will not be able to make any progress.

So I have concluded we have to defeat the Mitchell bill. We have to defeat what essentially is the President's proposal. We have to defeat the Gephardt bill. And we have to send that message, and then and only then can we begin to put together the needed reforms that will truly preserve what is right about our health care system and make changes in those areas that do not work right.

The American people have said they do not want or they do not trust Government to take over the health care system of this country, which is one-seventh of our economy. They do not want or trust Government to make decisions about issues that are the most personal issues in their lives. That is the health of themselves and their spouses and their loved ones and their children.

They do not want most of the critical decisions regarding their health care settled on a political basis.

This is the fundamental issue: Do we as a people want Government-run health care? The American people are saying no. They do not know the details, but their instincts are correct. And those instincts are shaped by experience, time after time after time, with Government-run programs.

That message has to penetrate the White House and only when it does, only then can we begin the process of real health care reform.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from New York.

Mr. MOYNIHAN. Mr. President, before the Senator from Indiana leaves the floor, could I, with great respect, suggest that either I misspoke or was misunderstood, and that is probably both as it frequently happens.

I mentioned surprise to find in Senator MITCHELL's bill provisions that indicate that the Federal Government will designate the number of specialists that will be trained for specific specialties and then will reduce the number of residents, and so forth. I said there must be some staffer who wants that because we had thought it was being taken out of the majority leader's bill. It never was in the Finance Committee bill, and the Finance Committee staff did not add it, as I am sure Senator PACKWOOD will agree.

Mr. COATS. I did not believe it was the Finance Committee.

Mr. MOYNIHAN. They were much concerned.

Mr. COATS. It was distressing. It was on someone else's staff.

Mr. MOYNIHAN. I wonder if the Senator might consider revising his remarks in that regard.

Mr. COATS. Mr. President, I am happy to revise the remarks, based on the statement made by the Senator from New York, implicating a member of the Finance Committee staff as being responsible for the quota system set up for medical specialties under section 3012. Apparently that was inserted by either staff of another Senator or some other staffer but not a member of the Finance Committee or the Finance Committee staff.

Mr. MOYNIHAN. That is right. I appreciate the courtesy.

Mr. President, this question of Government-run medicine, we are going to hear a lot about that.

May I just offer the thought in a bipartisan spirit—and I was happy to hear the Senator from Indiana speak of a bipartisan spirit; happy to hear him speak of Bluffton, where my grandfather, who dug pipelines from Jamestown, NY, around central New York, ended up.

Medicine, by the oldest experience of the Western civilization, is a socialized activity. Individual doctors, no; but hospitals, yes.

There are some for-profit hospitals in the country. Perhaps 15 percent of the patients are in them. But it is not a profitable activity. It is, by definition, socialized.

The largest activities, say, in my city of New York, the main hospitals are religious-supported hospitals. They are Catholic, they are Protestant; Columbia Presbyterian, St. Luke's, Mount Sinai, Montefiore, the latter being associated with a Jewish charity; as a Presbyterian charity; as a Catholic charity.

The Shriners run extraordinary burn centers around the country. There are Masons. And there is never a bill.

We have the hospital systems we have because of generosity from the charitable, the sharing concerns of Americans, not as an enterprise. And I hope we keep that in mind.

I quote my Republican friend, who accompanied the President to the Middle West yesterday, the mayor of New York, who said in a letter to the House, "America is debating universal health care. New York has given universal health care for most of the century."

It is a question of how much more, than whether. And I think we will see that.

I take the Senator's point about the vaccination program we authorized in the last budget. And Senator PACKWOOD and I realize that it is the responsibility of the Finance Committee. It has not gone well. We will have to hold a hearing, and we hope we can do better. But we have had free vaccinations provided by the city of New York in New York since 1890. And it has not turned us into a hopelessly communal society.

Mr. PACKWOOD. Will the Senator yield?

Mr. MOYNIHAN. I yield the floor.

Mr. PACKWOOD. I do not want him to yield the floor.

The PRESIDING OFFICER. Who yields time?

Mr. PACKWOOD. I yield myself a couple of minutes.

We have reached the level of vaccinations that we had hoped to reach in the legislation that we passed. It is not only in the city of New York, but we have found this in any number of towns in major metropolitan areas where we have tried and tried and tried to vaccinate everybody. The problem is not the lack of vaccine. The problem is getting people to wherever your communal vaccination facility is to do it. And the cost has not been the deterring factor. We do not know why they will not. But it is not a question of the vaccine, which was free.

I thank the Chair.

Mr. MOYNIHAN. Mr. President, I make that point. The determinants of health increasingly in the modern world has to do with personal behavior and community behavior.

The change in infant mortality in the world is really striking. How much better things are than they were.

I look at Portugal. In 1960, it had an infant mortality rate of 77.5 per thousand. One child in 13 died before reaching one year of age. It is now down to 11 per thousand or one child in 99.

The United States, which was never that good—it helps to be born in Iceland if you want to prosper as a child—but we were 11th among the 23 OECD countries in 1960. We are now 21st. Not because we have forgotten medicine; medicine roars forward. But, community behavior is less than it obviously once was.

Mr. President, I see my friend from Massachusetts and I yield to him for such time as he may desire.

Mr. KENNEDY. I thank Senator MOYNIHAN.

We are going to get back very quickly to the Dodd amendment on children, and also the comparisons between the Mitchell program and the Dole program, not only on children but on working families and seniors.

But I wanted to just take a moment, before yielding to the Senator——

Mr. REID. Will the Senator from Massachusetts allow me to ask him a question?

Mr. KENNEDY. I will be glad to. Could I just make one brief comment on a matter that I brought up earlier, and then I will yield for a question.

That is, we are hearing on the floor now about how we continue to study the different proposals and find new insights.

I must say that I share that experience, just in the past few hours in further study of the Dole proposal. Earlier I had spelled out the difference on one very key element of the Mitchell proposal and the Dole proposal on the exclusion of treatments for preexisting conditions, which is an absolutely essential part of the different proposals.

I mentioned in the comparison, when I was exchanging comments with the Senator from South Dakota [Mr. DASCHLE] about how the Dole proposal provides that if you are diagnosed or being treated during the 3 months prior to the time of the enrollment, you are therefore excluded, or you are limited in terms of any kind of help and assistance or medical attention for 6 months.

So I looked over on page 81 and found this 3-month period where you would be treated and the limitation of 6 months.

On the next page, it says, "Special rules for individuals." So in the case of an individual who is not enrolling as a member of a group but as an individual, 3 months in paragraph 1(a) is deemed a reference to 6 months. So it is not 3 months, it is 6 months. And in paragraph (b), any reference to 6 months is deemed a reference to 12 months.

So, I agree that 12 months without medical treatment is absolutely devastating for any individuals who are trying to get attention for a medical condition.

But then if you just read further, because we talked about an amnesty provision, which was included in the leader's provision, and also the first open enrollment where they can enter into a program without any exclusion of coverage.

And now we have heard our friend from Indiana talk about the bureaucracy in the administration of the leader's proposal.

Listen to this. Under the Dole proposal, there is also an amnesty provision, but in general this subsection shall not apply during an initial enrollment period described generally, but

the participating State may establish a limit on the number of new enrollees a health plan must accept during the period described based on the plan's share of the applicable community-rated or experienced-rated population.

Now you talk about a bureaucracy. Here the Dole bill says they are going to give it to the State to develop some kind of agency when they are having this limited amnesty period, and then the State is going to decide—on the basis of what? Capacity—who is going to get in and who is going to be left out.

You talk about playing God. You talk about the Mitchell proposal, trying to include people and having administrative procedures to include people—here, under the Dole proposal they are creating a new State agency to keep people out; to keep people out.

This is wise, to try to get through exactly what is the bureaucracy in the two proposals.

Mr. DASCHLE. Will the Senator yield on that point just for a clarification? As I understand it, if that interpretation is correct, then you would have a State governmental agency deciding the eligibility for insurance for every individual with a preexisting condition? You could have someone in North Dakota who has a preexisting condition who would be eligible for care, but a person in South Dakota with the same preexisting condition where Government says you are not allowed any access to that insurance? Is that what that provision says?

Mr. KENNEDY. It is stated. The Senator is exactly correct. The participating State may establish a limit on the number of new enrollees a health plan must accept. So they decide who they are going to accept. There is no consistency in terms of trying to make sure you are making a commitment to those individuals, our fellow citizens who have a disability, and say they are part of this whole process; they are part of the whole process. Here it says the State will establish an agency. The State will decide who will come in and who will be left out.

I think the Senator's interpretation is correct.

Mr. REID. Mr. President, will the Senator yield?

Mr. KENNEDY. I will yield for a question and then yield whatever time, yield the floor.

Mr. REID. Mr. President, through you to my friend from Massachusetts, you will recall the junior Senator from Indiana said, and this is not an exact quote: I am not prepared to go forward on health care legislation. I ask my friend from Massachusetts, is it not true that we have been talking about health care, universal health care, for over 50 years in this country?

Mr. KENNEDY. The Senator is absolutely correct.

Mr. REID. Is it not true we have gone through about six Presidents, talking health care?

Mr. KENNEDY. Certainly Teddy Roosevelt, Franklin Roosevelt, Harry Truman, President Nixon——

Mr. REID. It is also my understanding the Education and Labor Committee and the Finance Committee have held more than 60 hearings on the legislation, the one reported out by the Finance Committee, the bill reported out by the Education and Labor Committee—much of which has been melded into the Mitchell plan? Over 60 hearings; is that right?

Mr. KENNEDY. Over 80 would be more accurate.

Mr. REID. And hundreds of witnesses, is that true?

Mr. KENNEDY. The Senator is correct.

Mr. REID. I am wondering, do you think the Senator from Massachusetts is ready to go forward with this legislation?

Mr. KENNEDY. I think the American people are ready to go. They are ready for the Congress to finally address the more important issues of our time.

Mr. REID. I would say to my friend from Massachusetts, talking, for example, about preexisting disabilities, preexisting conditions, in the small State of Nevada—and it is a small State—we have about 360,000 people with preexisting conditions. Now, under the Dole plan, as has been explained by the Senator from Massachusetts and the Senator from South Dakota, most of them are still out of luck; is that not right? Under the Dole plan, preexisting conditions—in the small State of Nevada we now have about 360,000 people with preexisting conditions. They would still basically be out of luck; is that not right?

Mr. KENNEDY. Certainly they would be out of luck if they have been getting any kind of treatment for 6 months prior to the time—they would be out of luck for the next year for any other kind—any kind of treatment and assistance. If you look at the nature of these kinds of diseases—cancer, heart disease, diabetes, HIV, the whole range of different kinds of diseases—that is the time when people really need the help and assistance. In effect, they would be excluded.

Mr. REID. I hope later on in this debate, we will have an opportunity to talk about some of the other things that need to be addressed, like helping the small business people in this country; like helping women who need prenatal care. I hope we will have the opportunity during this debate to indicate now is the time to go forward with health care legislation for the people of the State of Nevada, the people of the State of Massachusetts, and throughout the United States.

Mr. KENNEDY. I thank my colleague. We are back, hopefully, to the excellent amendment of the Senator from Connecticut.

I think for——

Mr. COATS. Mr. President, may I ask the Senator from Massachusetts to yield to me just to respond in 30 seconds to the Senator from Nevada?

Mr. KENNEDY. For 30 seconds.

Mr. COATS. I thank the Senator.

Perhaps the Senator from Nevada was not here when I spoke last evening. Or maybe he did not hear my entire statement today. If he misinterpreted my statement or if I misstated in my statement, I apologize for misstating it.

This Senator said—meant to say—I am not prepared to go forward with the Mitchell bill or even the Dole bill. I have not had time to analyze it all. I doubt if any Member here has. Certainly, I am prepared, as I indicated in my statement—I closed with it—to go forward with meaningful, sensible health reform legislation. I am not prepared. I do not fully understand—even the Finance Committee chairman said he did not realize the section was in the bill. I do not think any of us have had the chance to fully analyze the situation to the point where we can just do the bill now and get out of here and go home. That is what I meant to say.

But I say to the Senator from the State of Nevada, the premise of the Senator's statement, if it was based on my statement, I think the Senator was wrong.

Mr. KENNEDY. I see the Republican leader. I was wondering if there had been any decisions on the resolution of the two amendments that were going to be voted on—hopefully voted on—on Monday at 5 o'clock. I think the majority leader had indicated he was hopeful of being able to get some kind of response on that request.

Mr. DOLE. I will be meeting with Senator MITCHELL at 1:45 on another matter, and I will be happy——

Mr. KENNEDY. Fine. I thank the Senator. I yield the floor.

The PRESIDING OFFICER. Who yields time?

Mr. MOYNIHAN. I yield the Senator from Connecticut as much time as he desires or may require.

Mr. DODD. Mr. President, what is the pending business?

The PRESIDING OFFICER. The Dodd amendment No. 2561.

Mr. DODD. Mr. President, I am glad to hear that. To paraphrase Daniel Webster: It is a small amendment, Mr. President, but there are those of us who love it. It is only two pages long. I proposed it last night at 5 o'clock. I gather we are not going to be able to vote on it until maybe Monday or Tuesday. But I just wanted to bring us back a little bit to the subject matter before this body, which I introduced going on 24 hours ago. It is not a difficult amendment to read.

I understand the overall bills are longer but this amendment is just two pages and pretty straightforward as to what it does. I am disappointed we cannot get a vote on it sooner. I just hope we will get a vote at some point.

Just to reemphasize the point that was being made by the Senator from Nevada a moment ago—I hear some people saying how we need a lot more time on this issue before we go forward.

I sit on the Labor and Human Resources Committee. We had 51 hearings on this subject matter in just that committee alone. There were some 30 or 35 different hearings, as I recall, in the Finance Committee. Roughly 40 Members of this body serve either on the Labor and Human Resources Committee or the Finance Committee.

If you add the Veterans' Affairs Committee and the Governmental Affairs Committee, each of which had hearings on this subject matter—and then you consider all of the network programming, all of the stories, the opinion page pieces done on this, the American public is now familiar with a language that I think a year and a half or so ago they would have been totally unfamiliar with; things like preexisting conditions, portability, and the various kinds of plans.

I just want to make the point here that we have had an endless amount of information made available to us. The subject matter of our discussion here should now be tremendously familiar to Members. We must not miss this opportunity. I hear some Members talking about not being ready to proceed. It reminds me of students the night before a school paper is due who have not done their homework. So, a student shows up the next day and says the dog ate his paper and he is very sorry he could not get it done. Or another student takes an incomplete at the end of the semester because he or she did not study.

We cannot take an incomplete on health care. We cannot just quit and go home. Congresses exist for a finite period: 2 years. We are coming toward the end of this 103d Congress after a significant amount of work on health care—including hearing from hundreds of witnesses in countless numbers of hearings.

So while I am certainly patient about people wanting to study and read a bit more, I think this may not pass the smell test, as they say. What we may be really looking at is just some good old-fashioned foot dragging.

So I am hopeful that we might get a vote on my two-page amendment at some point because it is pretty straightforward. It deals with children. It requires private insurance policies to cover pregnant women and children. I will go over it in a minute. That is all it is. It is not a Government program. It does not create some fancy new bureaucracy. It moves the date up for coverage for kids from 1997 to 1995. This should not be heavy lifting in terms of getting us to vote on this. People around here who think we need to study, study, and study some more are not convincing this Senator, and I believe other people, about why that is necessary.

So, let me come back again, if I can, to the subject matter before us because I think a critical point needs to be made over and over and over and over again.

If you are a family living on public assistance today in 1994, your family gets health care. What we are talking about when we talk about those who are not covered are families who are working. They get up every morning and go out the door and hold down a job and try to provide for themselves and their families. They are the ones that are being excluded from basic health care coverage in too high numbers. So we are trying to do what we can to see that they get drawn into the process. That is what this is really all about. Because people talk about this program as some sort of a giveaway, I would just like to share with you some testimony I heard when chairing a hearing before the Children's Subcommittee. My colleague from Indiana serves as the ranking minority member of that subcommittee.

Lynn Morrison testified before our subcommittee last November. Let me read a little of her testimony if I can, because we need to put a human face on the numbers and charts we have before us. While Lynn is only one woman, she speaks, I think, for literally hundreds of thousands in this country:

My name is Lynn Morrison. I want you to know that I'm an average working person. I've worked since I was 14 years of age. But when I was pregnant with Desiree and needed help in getting health insurance, I couldn't get it.

I'm here today to tell my story so that maybe other women won't have to go through what I did. Others won't have to be afraid when they can't get in to see a doctor before they deliver. Others won't get late prenatal care like I did and risk having a problem.

This year money was tight, even though we were both working. We had just bought our first home and had a monthly mortgage to pay. My husband and I had not planned this pregnancy. This was not the best time to have a baby. But my husband and I were delighted to bring a new baby into the world, to care for her and to give Rachel a new sister.

When I learned I was pregnant, I had just changed jobs to be closer to Rachel's kindergarten. I left my job at a pediatrician's office because it was a 1½-hour commute and I had difficulty getting Rachel to and from school. I like my new job, but they don't offer their employees health insurance.

At first, I was not really worried because Rachel is school age and a pretty healthy child. I was feeling fine and healthy, too. When I learned I was pregnant, I tried to get on my husband's health insurance plan through his work. We learned they had been taking out monthly payments from his paycheck as if he had a family plan, but I was never enrolled. When he tried to enroll me with the health insurance company after I was pregnant, I was denied because my pregnancy was considered a "preexisting condition."

I really wanted this baby to have a good start. I was a little nervous. I was 32 years old.

She goes on to say:

Soon after that the welfare office—

She went and applied for welfare. I am leaving some of this out.

told me that my income and my husband's income combined would be too high to be Medicaid eligible. So I tried to find a doctor who would see me without insurance. I found one clinic who would see me, but they wanted $250 to $350 for my first visit and hundreds of dollars for blood tests. We just didn't have it. I was very scared. We were stressed and my husband felt terrible that he couldn't take care of my health needs. I was exhausted from the whole ordeal.

About this time, I was changing from sad and scared for my baby to mad. No one would see me. I thought, I've worked all my life and for what? No one will insure you if you need it, not even if you're pregnant. I have been putting money into the system for 18 years, and isn't it ironic that I can't get any health care when people who have not worked all their lives get Government help? My baby has a right to medical care. I don't understand why I can't get it just because I change jobs and we don't meet certain criteria.

I took the initiative and got on the phone and called around to find help. No one would help me. Before I had the baby, I went into premature labor twice and was hospitalized. I felt scared, but with the help of wonderful doctors—

Which she talked about, her baby was born healthy.

We are very lucky our baby doesn't have health problems. Everybody should be able to get health care if they need it. All this not only put our baby at risk, but we were afraid of losing our home and marriage. Because there is no guaranteed health coverage today, I couldn't get prenatal care until the fifth month of my pregnancy. I hope you hear my story and understand every American should have health care coverage, whether they change jobs, get sick, or have a baby.

I took the time to read that because I think as we go through this bill, we get up and read sections, subsections, talking a lingo and language that would glaze the eyes of an accountant, an actuary. Legislative language is difficult stuff to understand, to go through. We need to talk in terms of real people. Lynn is a real person and there are many, many more like her out there who are worried. This amendment tries to address her kind of situation.

(Mrs. FEINSTEIN assumed the chair.)

Mrs. MURRAY. Madam President, will the Senator from Connecticut yield for a question?

Mr. DODD. I will be glad to.

Mrs. MURRAY. I was startled, as I think most people were, when you read the story and talked about a woman who said pregnancy was a preexisting condition. I have had doctors tell me any woman over 16 has a preexisting condition. I think when we talk about that, we forget when a lot of women go to a doctor, try to find a new insurance

plan, that preexisting condition is something they thought was just part of their life. I think it is imperative we remember that during this debate.

I want to ask the Senator from Connecticut, I have heard from my own ob/gyn that many times he has young women, or women in their twenties sitting out in a car and they are in their ninth month of pregnancy; they are in labor and they sit out in their car and in the hospital parking lot until the very last second to go in to deliver because their health care coverage would not cover pregnancy.

Is this something that you heard in your committee hearings?

Mr. DODD. I thank the Senator for her question.

Madam President, I will tell you, this is something we heard over and over again—the nightmarish stories that people go through. Again, each of us ought to be doing everything we possibly can and not just because we are a civil society and because we care about people, but must also I point out that there are some real dollar savings involved here. We are constantly talking about the fiscal implications, as we should, of the various health care proposals. But let me just share, if I may, the incredible dangers of having a low birthweight baby if you have no prenatal health care.

Each year, there are some 250,000 babies born to women who do not receive the necessary kind of prenatal care before the sixth month of pregnancy. These babies are twice as likely to be born with a low birth weight. More than 90,000 infants were born to mothers who did not see a health care provider during their pregnancy at all. These babies are three times more likely to be born with a low birth weight than those mothers who received the appropriate prenatal care.

What does that mean in terms of dollars and cents? Usually, you are looking at a child that ends up in a hospital—and I am sure many of my colleagues have been to these infant intensive care units. It is remarkable what they can do from a technology standpoint, but do not kid yourself, their work is very expensive. It is not uncommon for the cost to be $150,000 to keep one of those infants alive in one of those incubators. I am just stunned by the capabilities that we have in this area. It is wonderful. But it costs a tremendous amount.

Mrs. MURRAY. Madam President, will the Senator yield for a question?

Mr. DODD. I will be glad to yield.

Mrs. MURRAY. The Senator mentioned the tremendous cost of low birthweight babies and mothers who have not had good prenatal care. As a former preschool teacher, my experience was that the young kids when they got to be 3, 4, and 5 and were in my preschool class were the ones that were further behind, took longer to learn, and were much more difficult. Do those costs reflect further in life as these low birthweight babies grow up?

Mr. DODD. It does. As the Senator has correctly pointed out, there are costs when that child enters school without the kind of learning capacity that they should have and a variety of other problems. The following numbers were developed by the Carnegie Foundation, the March of Dimes, and others. Every time a low birthweight delivery is prevented, it saves between $20,000 and $50,000. Every time a low birthweight delivery is prevented, it saves approximately $150,000 or more on neonatal intensive care costs per child.

Mr. REID. Will the Senator yield?

Mr. DODD. I would be glad to.

Mr. REID. I had two gentlemen from Nevada come to my office who were neonatalogists. They indicated—and I think it is a confirmation—I would like the Senator to respond—of what he is telling us here—it is not unusual in their facility to have women come who have never ever seen a doctor, and they are there for delivery, and that they do not have babies that cost $150,000; they have million-dollar babies. By the time the baby gets out of a hospital the first time, the hospital bill is $1 million. Has the Senator heard of cases of that nature?

Mr. DODD. Certainly. In years back, those children would have died. And today, because of our commitment to research and technology, we can now save those lives. But they are tremendously costly. And again, you will hear over and over about the low cost and savings from prevention. I called Travelers Insurance Co., by the way, and asked about my amendment and said, "How much will this cost?" It is 9 cents a day to cover children's care. That is 9 cents a day in premium costs.

By the way, my insurance companies do not oppose this amendment. We hear about the insurance industry and some of the things that are said about them, but I want my colleagues to know that they are behind this and believe it is an acceptable step. Many of them have it already in their plans. A lot of the HMO's have it in their plans and insist upon it. Some 20 States require it. So this amendment would just insist that any private insurance plan cover it as well.

Mr. REID. Will the Senator yield for one final question?

The Senator from Washington stated the problems that women have can be preexisting conditions. To indicate that this is not just a fallacy, I have an organization, a nonprofit organization in the State of Nevada that wrote me a letter—I talked about it once a couple months ago on the floor—the National Association of Latin Americans. They have 23 employees. They had health insurance, and the reason they were able to maintain employees is they had health insurance. The average wage was $4.50. They were glad to work; they had health insurance. They were unable to find someone that would renew or write a new policy because they had preexisting conditions that had developed during the year. Two of the conditions were pregnancies. One of the conditions was diabetes. They were canceled.

Is this what the Senator from Connecticut is talking about?

Mr. DODD. Exactly. Those are exactly the kinds of conditions and problems that people face. And I would like to, Madam President, if I could draw the attention of my colleagues to this chart or graph here. There are a lot of numbers and language here but let me briefly try to explain the comparison between the Mitchell plan and the Dole plan when it comes to children and how they are affected. We are talking about the children of working people here now.

These numbers here on the side of this chart are income levels starting at $14,000 going up to $44,000, which is 300 percent of poverty.

Under the Mitchell plan, the amount of premium you would pay for children is zero through 150 percent of poverty.

I would point out that under the Dole plan, the cost of a family policy does not cost you anything at $14,000, but when you jump up to $22,000, 150 percent of poverty, you don't do very well. Under the Mitchell plan, there is no cost. Under the Dole plan, you pay $5,883, in excess of 26 percent of that family's income.

Mr. PACKWOOD. Will the Senator yield for a question?

Mr. DODD. I will in a second. Let me finish the graph. You go to $29,000, $36,000, $44,000. These are working people. We have made a significant effort in the Mitchell plan to assist those families, particularly at that level.

The highest cost a family at the $44,000 level for these children is a little in excess of $1,700 a year—4 percent of that family's income.

One of the things we want to try to do here is not bankrupt people who are out there earning a living, trying to provide for their children's needs. And health care is costly. And so the Mitchell plan makes a significant effort to assist those working families with children and see that they get the kind of support and backing that they need.

With all due respect—as I said last evening—and I will repeat it here now because I do not want to hear it said later, there have been very few people in this Chamber who have fought harder and cared as much about kids as Bob DOLE of Kansas. Food stamps, WIC programs, he has been there.

Now, my reference here is the——

Mr. PACKWOOD. Will the Senator yield?

Mr. DODD. In a second I will. There is a significant difference and people

ought to take note, a significant difference. If you are in that $22,000, $29,000, $36,000 range, under Mitchell you are paying less than 1 percent at $29,000, 2.7 percent of your income at $36,000, 4 percent of your income at $44,000. Under the Dole proposal, at $22,000, you pay 26 percent, at $29,000 you pay almost 20 percent, at $36,000, you pay almost 16 percent, and at $44,000, you spend 13 percent of your income for coverage.

Mr. PACKWOOD. I do have a question.

Mr. DODD. One quick question.

Mr. PACKWOOD. Yes. What benefit package is the Senator using to estimate the Dole-Packwood bill?

Mr. DODD. The Dole bill only covers the family policy. It does not pick up children separately. So there is a distinction. But this is how families are affected across the board.

Mr. PACKWOOD. Where does the Senator——

Mr. DODD. Let me finish. Then I will yield to my colleague.

Mr. PACKWOOD. Where does the Senator——

Mr. DODD. I will yield. Let me answer the question. The Mitchell plan provides for children specifically whereas the Dole proposal covers the family. The coverage and the cost is the same. That is why we have this amendment.

Mrs. MURRAY. Will the Senator yield?

Mr. DODD. I will be glad to yield.

Mr. PACKWOOD. My question is where did the Senator get——

The PRESIDING OFFICER. The Senator from Connecticut has the floor. He has yielded to the Senator from Washington.

Mrs. MURRAY. I thank the Chair, and I thank my colleague from Connecticut.

They probably heard me when I made my opening remarks the other day talk about a young child who I had in my preschool class who was unruly and disruptive, and after observing him I noticed he could not hear, he had ear infections. And I went to his mother and suggested she take him into the physician and help him. It did not occur, and after 3 weeks I went back to her and I said, "Have you taken him in?" And she looked at me in tears and said, "We don't have any health care insurance."

Now, there is a child who remained a problem in my classroom simply because of ear infections. His family did not have coverage. I would guess their income was probably in the $22,000 range. Under the Mitchell plan, what would be the premium she would have to pay?

Mr. DODD. As it is written now—it may be changed if people want to knock it out or modify it—but right now under the Mitchell plan, that family is protected up to 150 percent of poverty so that they would not have a premium cost for those children.

We understand the value of that. If their income falls into the $30,000 range, they participate and pay something. We are trying to help out working families in this area so that that woman——

Mrs. MURRAY. That child would then have gone into the doctor, had his ear infections fixed, and been back and been a nondisruptive member of the class.

Mr. DODD. That is absolutely correct. The Senator made a point. Again, in stating the statistics, Madam President, there are implications here—Lord knows, there are implications. We know now that a dollar invested in prenatal care can save on the average $3 to $4.

So the investment, in the case of a pregnant woman, with the kind of care that we can provide today, does a tremendous amount to save costs when you face the problems that these infants incur with low birthweights. Now, I would say my colleague from Oregon is absolutely correct, in my view, regarding vaccines. My State of Connecticut has a free vaccine program, and I have gone out day after day, in area after area, Hartford, Bridgeport, New Haven, with clowns and food and gimmicks and everything else to get people to come out and take advantage of it. And they do not.

We have a hard time with that. We have to think of more creative ways of doing it. But, nonetheless, it is critically important that these children get some assistance.

So this amendment that is the pending business, Madam President, does not create a bureaucracy. Very simply, it requires every private insurance policy in the country to include preventive services for children and pregnant women in their basic benefits package by next summer.

Let me conclude on this note. I see other colleagues want to address these issues. I come from Connecticut. I come from the insurance capital of this country. I have 55,000 constituents who work in the industry. I also have 23,000 constituents who lose their health insurance every month. Most of them get it back before the year is out. But God forbid something happens to them during that year.

I would not be standing here supporting a program that would destroy the private industry involved in health care. They have done a very good job, in my view. I know other colleagues may have a different point of view. But I believe they have done well. This bill builds on the existing program. It does not tear it down. This amendment specifically builds on the existing program. That is why I think it is important and why I believe it can make such a difference in these young children's lives and their families' lives.

Mr. KENNEDY. Will the Senator yield just on the question about the estimates? As I understand—I would be interested if he agrees—the benefits packages estimate is from the CBO for Mitchell, and both the Mitchell and Dole are estimated equal to Blue Cross standard under the Federal Employees Health Benefits Program. As I understand it, the Dole probably is actually higher because the community rating pool is smaller. It is outlined on pages 86 and 87. But as I understand, that is how the estimate came. Am I correct?

Mr. DODD. The Senator from Massachusetts is absolutely correct. We are talking about the children's features. In the Mitchell bill, we go beyond 150 percent of poverty and try to do something for those families.

Under the Dole proposal, there is an effort, and 100 percent and up to, I guess, 150 percent. It stops at 150 percent.

Mr. KENNEDY. Nothing above 150.

Mr. DODD. That is correct.

Mr. KENNEDY. There is no program in there for children?

Mr. DODD. That is correct. That is why, under the Dole proposal, at 150 percent of poverty—in excess of $22,000 a year—you are going to be in the same category as the person making $44,000 a year when it comes to children. In fairness to Senator DOLE, up to 150 percent the plans both help families. I happen to believe if you are making 200 percent in excess of poverty or 300 percent, you are not a wealthy American. You are a middle-income family trying to hold it together, pay mortgages or rents, clothes, God knows what else. These are not affluent Americans. To suggest that those families can afford 26 percent of their gross income for health care premiums is excessive, in my view. Maybe others do not think it is, but I think it is. That is why the Mitchell proposal is so much better.

Mr. KENNEDY. If I could just ask the Senator about this chart over here. The Senator has addressed the questions about what is happening under the Mitchell program, as I understand it, which has the unique program which is directed toward children. The Senator's amendment addresses this concept and accentuates the benefits of it at an earlier period of time. As I understand it, it has the support of many within the industry as compared to the Dole proposal.

The only question I would like to ask is whether the Senator agrees that we are basically talking about families of working men and women. The Senator has pointed out correctly that those are the most needy children of working families. The poorest are covered by Medicaid.

But does the Senator agree with me that there is a parallel in the difference between the Mitchell program and the Dole program, not just in terms of children, but also for working families;

that the effort of the Mitchell program was to again try to get a very, very affordable program for children, which are the ones that have been left behind in the special interests?

But does the Senator not agree with me that, if you look further down the road in terms of the Mitchell plan and the Dole plan with regard to working families, you see that dramatic difference again reflected in the amounts that would be required in terms of payment? Under the Mitchell program, we still try to keep that figure down. Here you see 4 percent, 6 percent, 8 percent, and 10 percent. Under the Dole program, it goes 12 percent and 26 percent. At $22,000 for a family of four, it is 26 percent, and, particularly since you are talking about the voluntary program, it is going to be virtually prohibitive and really not a program at all.

Mr. DODD. The Senator is absolutely correct. As I pointed out last evening, of the 37 million Americans who have no health insurance today, 12 million are children. They represent roughly 25 percent of the population of the country, yet closer to 36 percent of the uninsured. Eighty-two percent of the adult population are working Americans. If you are on public assistance, you get health care today in America.

As I pointed out last evening, if you are incarcerated in America today, you get health care. But if you are working, it is difficult. Most of the uninsured are working.

I do not have the chart with me, but let me make one last point which I think ought to startle people because of where the trend lines are going. In 1987, 64 to 65 percent of the children of working families, working either full time or part time, had employment related health care coverage. In 1992, that number is now around 59 percent. The number of children who are receiving insurance in families where there are full-time jobs or significant part-time work is declining. The trend lines are moving in the direction where fewer and fewer children are getting covered because of the tremendous costs.

So while you can say, "Well, Senator, look, 60 percent are still covered," you are right. But it is down from 65 percent of just a few years ago and heading in the wrong direction. So while that may be OK for you today, I just caution you. If you think the status quo is doing nothing, folding up our tent, going home, taking the incomplete, in effect, because we did not want to sit around and address these hard questions, you are going to be in potentially greater difficulty as a working family out there in meeting the health care needs of your children. That is statistically the case as you watch those numbers move in the wrong direction, I think, by everyone's estimate.

Mr. REID. Will the Senator yield for a question?

Mr. DODD. I yielded to my colleague from Minnesota.

Mr. WELLSTONE. I yield.

Mr. REID. Just a brief question: The State of Nevada has the highest teenage pregnancy rate in the United States. In addition to that, almost 50 percent of the teenaged mothers have never had prenatal care; zero. Would the underlying bill and the amendment suggested by my friend from Connecticut help the young women in the State of Nevada?

Mr. DODD. I say to my colleague, absolutely. What we are doing here is requiring the private carriers to have this kind of service, to make it available in July 1995. It does not seem like much to many people. But 18 months could make a big difference to these families.

Of course, under the Mitchell proposal, the subsidies go up to 300 percent of poverty. I am presuming that by and large, these teenaged mothers come from poorer families, and are poorer, obviously, given their age and their inability to earn higher incomes. They are going to be particularly assisted in this process, and they should be able to get help.

The Senator from Oregon brings up the point that we have to get them there, too.

So I think it is a critically important question.

Mr. WELLSTONE. Will the Senator yield? First of all, would the Senator agree with me? I have a chart. Actually, when you look at those Americans that are without insurance, a disproportionate number of them, in fact, are working middle-income families.

Mr. DODD. The Senator is absolutely correct. I am stunned that people do not see that. The notion out there, I think, is that the uninsured are all on public assistance, that these are welfare recipients who do not want to work and are just living off everybody else's labor. I am just amazed by this, because the fact is that 82 percent of those without health coverage are working Americans. They may be holding a low-wage or low-salary job but they are working. In a sense, we are trying to amend the welfare laws in this country. If you have kids, you would almost have to be out of your mind to get off welfare and take a $6 an hour job with no health care coverage.

We are trying to get people off welfare and into private sector jobs. What is the inducement if you go out there and take that job and you lose the health care coverage you get as a welfare mother? What is the inducement? You can almost argue that you are being irresponsible to your children if you go off welfare and lose all health protection for them.

We are trying to get people off of welfare without losing health coverage. That is the biggest incentive to decrease welfare dependency I know of. You talk to welfare recipients and they are scared about not having health care coverage for their kids. It is going to be hard to make any progress towards getting people off welfare if we do not provide a good health care system for those kids.

Mr. WELLSTONE. What the Senator is saying is that you actually can have a true welfare reform bill where women or men—usually women are the single parents—are able to work and support their children—although I believe he is saying being at home with the children is very important work. But unless we do something about health care reform to make sure they do not lose their Medicaid on AFDC. Is that what the Senator is saying?

Mr. DODD. The Senator is correct. I feel so strongly about it because we do not value enough those people who say: Look, I am going to try and do this on my own. I do not want to ask for anybody's help. I am going to take that job and try to provide for my family. They are going out that door and they do not get many good jobs, high-paying jobs, and they place their families at risk as a result. If you really claim to care about people and want to see them working, we must have health care.

I have always said the best social program designed by anybody anywhere is a job—a good old 9-to-5 or 8-to-4 job. Nothing does more for families, for one's sense of self esteem and self worth, then to be able to contribute to your family, your neighborhoods and community through a job. So if we are to try to get people to work, we have to do something on the health care issue.

We have about 20 legislative days left in this Congress. After all the work, hearings, discussion and debate, we are down to 20 days, and I am hearing people say, "I have not heard enough yet. I need to examine a bit more." Our various committees have held at least 80 hearings with hundreds of witnesses. Most of us in this body have attended hearings. In my case I participated in 10 days of markups in the Labor and Human Resources Committee as well, and I know there was a similar markup in the Finance Committee. The Presiding Officer may know, or my other colleagues may know exactly how much time was spent.

My Lord, my friends, what is the real situation here? We do not spend this much time on other complicated matters around here. To have somebody say, "I am sorry, I do not quite get it", is ridiculous. When I go home, the people in my State get it. They understand it. They want preexisting conditions eliminated; they want portability, and they want to see kids get covered in this country.

This is not magic. This is not that difficult. This is about rolling up our sleeves, deciding to work together and getting the job done. We have about 3

weeks left to do the job. The American public, I think, expects us to try. We may fail in the end, but let us not fail by filibuster. Let us try and get it done and try and work together. This tactic of 30, 40, 60 hours of general debate is not fooling anybody. This is the tactic of digging in your heels, slowing down the process, hoping the calendar runs out, hoping we go home, and hoping the American people lose.

I yield the floor.

Several Senators addressed the Chair.

The PRESIDING OFFICER. The Senator from Utah [Mr. BENNETT] is recognized.

Mr. BENNETT. I yield such time as he may require to my friend, Senator SHELBY.

Mr. SHELBY. Madam President, "Who shall check the Parliament?" Yes, who shall check the Parliament? John Stuart Mill asked this question over a century ago, and it is appropriate today.

Mill subsequently notes that:

> An assembly, if the cry of the moment goes with it, however hastily raised or artificially stirred up, thinks itself and is thought by everybody to be completely exculpated, however disastrous may be the consequences. Besides, an assembly never personally experiences the inconveniences of its bad measures until they have reached the dimensions of national evils.

Those were the words of John Stuart Mill.

Madam President, Mill frames for us the fundamental question that the Senate confronts at this very moment: Will we, in haste, and in the heat of battle, lose our measured and our judicious temperament? Will we, with no sense of culpability and responsibility for our rash actions, pass bad measures that will become national evils for present and future generations?—to paraphrase Mill.

Madam President, in the Federalist Papers, No. 62, Madison informs us that the Senate's constitutional necessity is marked by "the propensity of all single and numerous assemblies to yield to the impulse of sudden and violent passions." Madison reminds us that the Senate "must be, in all cases, a salutary check on the Government."

In the United States, it is the Senate that must watch the Parliament.

The American people are anxiously waiting to see if the Senate—this Senate—fulfills its constitutional role and checks the popular passions that have been unleashed in the rush to pass health care reform.

This health care debate is one of the most critical moments in the economic and social history of modern America. This Senate, Madam President, will decide whether or not we will have the most massive expansion of Federal power and spending commitments since the Great Society programs—a decision that will decide the future of every American's health care, the tax and financial burdens on our children and grandchildren, and the fundamental role of Government in the free market.

The private sector in Europe has created no net new jobs in 20 years as a result of high burdens on employers, big government, and untenable social spending commitments. Furthermore, Western Europe suffers from structural 11 percent unemployment compared to under 7 percent in the United States. As a result, the leaders of the European Community agreed in 1993 that lower labor taxes were needed to enhance competitiveness.

Yet, Madam President, while Europe struggles to throw off the yoke of these big government burdens, this Congress is preparing to put another burden on private employers in the form of insurance mandates, increased taxes on the American people, expanding Federal spending by over a trillion dollars in the next decade and, yes, and give the Government the major role in managing 14 percent of our economy through so-called health care reform.

Throughout the world, governments are slimming down and loosening the shackles on private enterprise. Yet, like a dinosaur, the United States trods down the well-worn path of bigger Government and higher taxes—a path that is less and less attractive to the other advanced industrial societies in the world.

A recent poll taken in my home State of Alabama found that 57 percent of Alabamians believe that Congress should take more time to study the health care issue, rather than acting immediately to pass legislation.

This number reflects the belief expressed by 46 percent of the poll's participants that the net effect of health care reform on an individual's personal health care coverage will be negative. Only 12 percent of the poll's participants felt that their health care would improve under this type of legislation that is before the Senate today.

Madam President, there is deep anxiety in my State, and I believe across the country, that in order to meet an artificial deadline set by the date of congressional adjournment, Congress will pass an ill-conceived, politically compromised piece of legislation—legislation that imposes substantial new tax and fiscal burdens on the American taxpayers and makes our current health care system, a system that provides the highest quality health care in the world, substantially worse.

One-seventh of our economy is tied to our health care system. It would be irresponsible for this Congress to pass legislation making sweeping changes in our system without due consideration and examination of the consequences.

Few Senators have had a chance to adequately review the contents or to consider the consequences of the voluminous document that we are now considering. Only since last week have we seen the bill language of the pending measure. Even more astounding, we are now looking at our third revision of that bill during the past week.

This is no way to reorganize one-seventh of our economy. It would take years to adequately assess the impact of this plan on every American's health care and his or her pocketbook.

At present, all we have is a scant two dozen pages of analysis from the Congressional Budget Office, an analysis that the office itself admits is hardly reliable.

The rush to pass health care reform has failed to take a hard look at the new fiscal commitments that will be made as a part of reform, or to adequately discuss what has become the second major raid on the American taxpayers in this Congress.

I did not support the massive tax increases passed by this Congress last year. I worked actively to defeat that measure and I will oppose the new taxing and spending binge by a taxaholic Congress called for by the pending health care reform bills before the Senate.

The Mitchell bill would put the burden of nearly $300 billion in new taxes over the next decade on the back of the American taxpayer. Most of these taxes will be raised through the taxation of every working American's health benefits.

The 103d Congress has already raised more taxes than any Congress in history. Passage of the Mitchell bill will only ensure that this legacy will not be easily undone or overcome by future Congresses.

I am opposed to employer mandates in any form. I am opposed to price controls. And I am concerned about the impact of so-called reform on the quality of our health care in America. However, the fiscal issues involved in health care reform remain my overriding concern here today.

The Mitchell bill, this so-called moderate bill, will make almost half of the American people dependent upon the Federal Government for their health care. Through the year 2004, the subsidies for expanded coverage will cost the taxpayer over $1 trillion—$1 trillion in new spending, with or without employer mandates.

The Mitchell bill proposes to pay for part of this massive new entitlement by putting four separate taxes on the working American's health benefits taxes that Senator GRAMM, and others, and I will attempt to eliminate from this bill.

One tax would put a 35-percent assessment on any benefits that an employer provides to an employee over a Government-determined minimum level. Can you imagine?

A second tax would levy a 25-percent assessment on health care premiums that exceed 2 percent real growth each year.

The third tax is a 1.75-percent excise tax on every health care premium in the country.

The final health benefit tax is a very cleverly concealed provision that would prevent insurers from offering discounts—can you believe it—for a healthy lifestyle and good health.

This tax would instead require these plans to make payments to underwrite high-risk individuals.

I am going to discuss these taxes at length in the future.

But I want to state here and now that the American people did not count on health care reform being financed on the backs of their hard won and well-deserved benefits.

The high-growth plan tax is not only a tax on quality health benefits, but is also intended as a form of price control that would result in rationing of health care services offered by health plans.

However, despite the cynical intention for the tax to reduce the American worker's health benefits to one-size-fits-all health plans that provide fewer benefits for the same amount of money, the tax will not control costs.

According to the CBO, this tax would provide little incentive for cost containment. Instead, the tax is a monster $70 billion revenue raiser that will increase the cost of the working American's health care premiums.

The Mitchell bill also contains a 1.75-percent excise tax on every health care premium in the country. Like all consumption-based taxes, this tax is a substantial revenue raiser, and it will grow.

However, like all sales and excise taxes, the working people of America will feel the pain of the tax in far greater proportion than will the well-to-do. Is taxing the middle class's health benefits to pay for bigger Government health care reform? I say no, Madam President.

This is the Congress that promised to make the wealthy pay their fair share. Yet, once again it is the middle class who must pay the bills for the Federal Government's unchecked growth.

Furthermore, Madam President, the taxes on excess health benefits strike at the heart of our fundamental freedoms and the American spirit. I could never support a measure that would limit any American worker or employer to a Government-defined health plan if they desired to purchase better for themselves or their family.

The right of any American citizen to improve his or her circumstances is as fundamental as the right to free speech or trial by jury. This tax would not do that. It is not right.

Madam President, Congress can take a few simple steps to reform our insurance market, reduce administrative costs, and make insurance more affordable to small businesses this year without giving the Government control over our Nation's health care system or levying new burdens on an overtaxed economy.

A vote for a bad health care bill is not a vote for reform. Health care reform should not become an excuse for expanding the size and power of the Federal Government.

Consequently, I will vote and work against any measure that levies new taxes on the American people, makes unrealistic fiscal commitments for future Congresses to meet, imposes job killing mandates on small business, or threatens to reduce the quality of a health care system that works well for 85 percent of the American people.

I believe Congress must do health care reform the right way or should wait until the next Congress. The stakes are too high to do otherwise.

Madam President, I believe the Mitchell bill is unwise, unworkable, and unwanted by the overwhelming majority of the American people. I urge my colleagues to oppose the Mitchell proposal.

I yield the floor.

The PRESIDING OFFICER. The Senator from Nevada is recognized.

Mr. REID. Madam President, I say in brief response to my friend from Alabama health care this year is going up over $100 billion. We have to do something about that cost of health care. Also the 17 percent of the people who have no health insurance are not the only ones who suffer. There are many people who have insurance who we call underinsured. It is a problem we must address.

I yield now 1 minute to the Senator from Virginia.

The PRESIDING OFFICER. The Senator from Virginia is recognized.

Mr. ROBB. Madam President, I thank the Senator from Nevada and the Senator from Minnesota, who has kindly permitted me to go one place ahead of him.

Madam President, I rise today to support the amendment offered by my colleague from Connecticut, Senator DODD, which requires that new health insurance policies or renewals include clinical preventative benefits—without copayments—for pregnant women and children.

This is a very important amendment, because it goes right to the heart of what we're trying to do in this health care debate: spend health care dollars wisely and rationally, and expand access to health care to those who really need it.

I would argue strongly that spending money on preventive care for pregnant women is a good economic deal. I would rather pay for prenatal and postnatal care any day than pay the hundreds of thousands of dollars it can take to care for a child in a neonatal intensive care unit—and I have visited many of them.

Ensuring that children get adequate preventive care, immunizations, et cetera, should reflect what we stand for as a Nation.

Some of my colleagues have spent a great deal of time talking about Lyndon Johnson and his commitment to provide health care to poor Americans through Medicaid and to our Nation's senior citizens through Medicare. I can tell you, firsthand, that Lyndon Johnson was a magnificently generous human being who personally felt the pain and suffering of the people around him. He truly felt injustice. He felt inequities. He was a large man who believed that wrongs could be righted if you had a good product to sell and you worked hard enough.

His oldest daughter, to my own good fortune, is the same way.

As Governor, I established the Southern Governor's Commission on Infant Mortality—and I appointed my wife, Lynda, to serve on commission representing the Commonwealth of Virginia.

During the last decade, Lynda has traveled throughout Virginia, throughout the South, and throughout the Nation—later as a member of the congressionally mandated National Commission to Prevent Infant Mortality—working to make people understand that providing preventive health care to pregnant women is just plain the right thing to do from an economic standpoint, from a moral standpoint, and from an ethical standpoint.

I thank the Senator from Nevada for yielding the time and especially the Senator from Minnesota who will now be recognized.

The PRESIDING OFFICER. Who yields time?

Mr. REID. Madam President, I yield 20 minutes to the Senator from Minnesota.

The PRESIDING OFFICER. The Senator from Minnesota is recognized for 20 minutes.

Mr. WELLSTONE. Madam President, I wrote a piece for the Minnesota Star Tribune a couple of weeks ago. I would like to read from the beginning, because it sets the tone and framework for my remarks on the floor of the Senate today, which are a little bit different from everybody else's.

I quote from the piece:

> Citizens beware. Health care that is always there is out, and triggers are in. All of you who worry about losing your coverage, who have no coverage, who are not covered for the conditions you most need insurance for, who pay too much for too little, are in danger of being told to just sit tight, all because several health care proposals circulating in Washington are generating a lot more attention than they deserve.

Madam President, let me start out with the obvious, because I think it has been lost in some of the debate. The obvious point is that the Mitchell bill, which represents a lot of hard work on the part of the majority leader, nevertheless leaves out some 14 million Americans for a very long period of

time. It is not a universal coverage bill.

Most people who are following this debate and who think about their own lives understand that when 14 million people are left out, that could very well be them.

Madam President, it is very interesting to me that, as we think about a hard trigger in 2002—if that in fact becomes necessary—that here in the U.S. Senate we are not waiting until 2002 for all of us to be covered.

And one more time, I do not think the Mitchell plan meets the standard set by so many of the speeches I have heard and so much of the rhetoric that I have heard that we ought to pass a reform bill that gives everyone as good a health care plan as we have for ourselves and our children.

Madam President, there is another issue—and this is far less a criticism of the majority leader's plan and far more a criticism of some of the alternatives or lack of alternatives we have heard from some other colleagues. I heard the Senator from South Dakota say he believes universal coverage is so important to cost containment. I heartily agree with his analysis.

Let me take it one step further. If we do not have universal coverage and we move to community rating, which we should do, the premiums for younger people go up, and then they do not participate because they do not have to. And then, in the language of actuaries, what that leads to is a death spiral where, in fact, people's premiums then go up for more people, and then more people drop out. It just simply is unworkable.

Madam President, earlier today we were talking about the Dodd amendment. I asked the Senator from Connecticut—and I appreciate his fine work—whether or not one of the most important aspects of his amendment was to go beyond very low-income people and get some early childhood care or prenatal care to a wider range of women and to their children; and was it not true that, among the 40 million people who have no health insurance, many of them were moderate income, working families? He said, yes. And I agree with him. That is why his amendment is so important.

But the fact of the matter is, whereas the President promised affordable health care, the majority leader's bill still leaves all too many families—when we get beyond this care and these services for women and children, but other services people need and other health care they need—still paying up to 20 percent or more of their family income just for health insurance premiums.

In other words, if you do not have employers paying their fair share—and please remember, colleagues, our employer pays 72 percent—then you have to go to subsidies. But if you want to keep the cost of subsidies down and only cover low-income or low- and moderate-income people, a lot of working and middle-income families do not receive any subsidy or any support. Thus, whether it be pretrigger or even posttrigger, you could still have families paying—and they do pay—20 percent or more of their annual income on premiums. And that is too much for middle-income people. As a matter of fact, I think we pay about 3 percent of our income, as Senators, for our plan. That is quite a difference, Madam President.

Third of all, there is another weakness in the majority leader's plan, for all the positive effort that he has made, and that has to do with low-income families and low-income people.

Madam President, I just would tell you that if we are going to continue to have a $10 copay in fee-for-service health plans, whether it be for Medicaid recipients or whether it be for low-income people, in the State of Minnesota and in many States with rural communities where we do not have HMO's, $10 will be too much.

We are all trying to emphasize family doctors and nurse practitioners and preventive health care. But if your child has a sore throat and you can't afford the $10, you will not go. It will not be universal coverage if it is not affordable. People simply will not go. And if we are talking about low-income families and children, I will just tell you that $10 copay is too much.

Finally, I worry to no end—and I wish this was more a part of the discussion—about two provisions in the majority leader's bill that I really think have to be dealt with in amendments.

Two points, Madam President: We set up commissions. We set up a National Health Benefits Board and we also set up a National Health Care Cost and Coverage Commission.

There is no requirement for consumer representation on these Boards. I will have an amendment saying we ought to make sure consumers are represented on these boards.

But what bothers me the most is the fail-safe mechanism that says that if we do not contain costs—and I am not at all sure we will be able to—automatically the National Health Care Cost and Coverage Commission will cut subsidies.

Well, if you are going to cut subsidies, you are going to cut subsidies for low- and moderate-income people. Are we going to privatize Medicaid, take low- and moderate-income off the coverage they have and offer them coverage in the private sector, only to find that if there is no cost containment, we are cutting their subsidies?

Why don't we really guarantee cost containment? What happened to insurance premiums caps? What happened to finding ways to overhaul health care costs? What happened to making cuts in our administrative load? Why would we want poor people to be the ones to be the first to be cut?

Another amendment is in order to strengthen that provision.

Madam President, the majority leader has really made an effort to bring a bill to the floor and I applaud him for that.

But then I see some of these other efforts.

Yesterday, we had the Boren-Nunn-Domenici-Bennett bill introduced. And I just would have to say—and maybe later on this will be a point of debate—there is no universal coverage in this proposal. It would cover only 90 percent of Americans. We are talking about leaving 24 million men, women, and children without protection. That is what CBO is going to say. That is what CBO has said about similar proposals.

I could raise questions about cost containment. I could raise questions about the comprehensive benefits. Where are the long-term benefits, where are the prescription drug benefits that are in the majority leader's bill?

Finally, just to signal what I think is going to be a very important debate, this proposal does not give States the option of implementing a single-payer program. Madam President, quite frankly, this is a little bit perplexing to me, because a good conservative principle—one, by the way, which I have shared almost all my adult life—is a critique of overly centralized and bureaucratized public policy. I have always felt conservatives have been right about that.

Decentralize health care. After we talk about some basic national goals and standards, let us let States decide on how they might finance and implement reform. Let the creativity and the development and the bargaining and the financing be at the State level.

Utah may not want to go single payer. In that case, Utah should not. But maybe Minnesota should. Or maybe Vermont would. Or maybe California might. And maybe Florida would do everything within managed competition. States are already laboratories of reform. Why would anybody be afraid of letting a State have an option to implement a single payer plan?

Then I read the New York Times today and I got the sense that the majority leader's bill—which does not have universal coverage, which does not include the same benefits that we have, which does not call for employers to contribute 70-some percent, all of which is what we have as Senators—may yet be even further weakened. Now there are all sorts of other discussions about how to water down the bill and weaken the bill. While at the same time, over and over and over again, the vast majority of people in the country say they are for universal coverage.

The vast majority of people in the country say they are for employers paying their fair share.

Madam President, these pieces of legislation are alternatives which further weaken the majority leader's bill, which is already quite weak in present form. I myself have made no decision whether I can support this bill in present form, much less if it is weakened. I think then support would be very problematical.

It will do nothing about the trends. In 1980, 24.2 million Americans were uninsured; 1992, 38.9 million. We cannot be talking about legislation that keeps things as they are or weakens the proposal given the kind of trends we see within our country.

(Mr. PRYOR assumed the chair.)

Mr. WELLSTONE. By way of conclusion, let me go to point A and point B. Today I sent a letter to the majority leader, with Senator SIMON, Senator FEINGOLD, Senator MOSELEY-BRAUN, Senator METZENBAUM, and Senator HARKIN. I will just read a paragraph.

As we continue to support your efforts to achieve affordable health care coverage for every American, we want you to know that we are gravely concerned about several aspects of the bill you have introduced. Further movement away from the goals of universal, affordable coverage would cause us to question even more seriously our ability to support the bill.

Mr. President, I want to make it clear that we meant those words and will be meeting with the majority leader at 11 a.m. on Monday. I will not read from the rest of this letter, but I will tell you, Mr. President, that for myself—and I think I speak for some of my colleagues, although they have very important amendments as well—we are ready to come to the floor with amendments to strengthen this bill. I want to give some examples.

There is no reason why we cannot achieve universal coverage for everyone sooner by having an earlier timeline for insurance reforms triggering an employer mandate by 1999 if necessary. We would like to find a way to get to this commitment we made earlier.

No. 2, Mr. President, we ought to improve the contribution that employers make. If in our case our employer contributes 72 percent of the premium, then we should have an amendment that says that as a matter of fact in this health care reform plan that should be exactly the way we move to financing. The same quality plan, as good as what we have. By the way, another amendment on my part will be a vote on the sense of the Senate that the final plan should provide people with as good health care as what we in the U.S. Congress have. That should be a yardstick.

Mr. President, there ought to be effective cost control measures. But if we do not stay within budget, we should not automatically trigger cuts in coverage for poor people. We ought to trigger a cap on insurance company premiums. I guess the insurance companies have a little more power than low-income people. Maybe that is what is going on. But I assure you, I will have an amendment on the floor that will do that.

If we are talking about employer mandates and about universal coverage, then I would make another proposal. It would seem to me that we might also think about what happens if matters get worse. So we will have an amendment to say that if coverage goes below 1994 level, we will have an automatic trigger for an employer mandate. What if only 80 percent are covered as opposed to 83 percent in 1994? Then we ought not to be talking about year 2002, we ought to be triggering employers paying their fair share earlier.

We have to talk about some kind of maintenance of effort. There are many, many people in this country that worry about a trigger that leads to 50–50 coverage when their employers are contributing 80 percent. What are we going to do to prevent employers from ratcheting down coverage they now provide? We need to come to the floor with an amendment that makes sure that does not happen to so many middle-income and working-income people, the very people we have been talking about all morning.

There is no reason why we should not have disclosure of CEO salaries as a condition of tax deduction, or to get subsidies.

Let me also say that there are a whole range of other amendments which I think will strengthen this, including making sure that consumers have representation on health care boards. If we are going to set up these boards and they are going to deal with cost containment and they are going to deal with benefits, then we absolutely ought to make sure that consumers have representation. I think of amendments that will strengthen the long-term care. I think of amendments that are important in mental health substance abuse. I look forward to introducing one with my colleague, Senator DOMENICI.

But I want to say today on the floor of the Senate that we have now reached the point where the majority leader has brought out a bill. It has some fundamental weaknesses. He believes it is a first step. I hope it will be a first step. Right now I am not sure. But what I do know is that some of these alternative efforts just simply weaken it and water it down to the point where, I guess, all of us can have a fancy name and an acronym and say we have done something great. But certainly it does not live up to the commitment we began with which is: We ought to make sure that each and every citizen, each and every man, woman, and child can afford humane, decent health care for themselves, their loved ones and their children.

We ought to make sure that the health care plan that we pass is as good as the plan we have. We are all covered. Another amendment I am considering with Senator SIMON says if we are going to have 95 percent coverage, then we ought to have an amendment to figure out which five Senators will go without coverage.

We are going to see that health care for everyone is as good as what we have in the Congress. Everyone is covered here, there are no exceptions for preexisting conditions, our employers contribute over 70 percent of the premium, and it is a good comprehensive package of benefits—though it could be improved. I think that is the standard. Over the next couple of weeks to come, we will have the amendments to strengthen it. If this bill gets further weakened, if this reform effort is hijacked, then there are some of us in the Senate who I think are going to fight as hard as we know how to.

Certainly I view this meeting with the majority leader on Monday as being important. It is quite one thing to present your very best as a reform effort and say it is a step forward. It is quite one thing to say, do not make the perfect the enemy of the good. I agree. It is quite another thing to get to the point where you have a piece of legislation that is so weakened, so watered down, so hijacked, so blocked by all those huge interests that have poured all that money into Senators and Representatives with all their power and clout with the people who need this reform the most left out. It seems like the people who need the change do not have the power, and the people who have the power do not want the change.

Whether we reach that point—and I think we are close to it—I think there are a number of us in the Senate who will draw the line in the sand on that.

I yield the remainder of my time.

The PRESIDING OFFICER. The Senator from Utah.

Mr. BENNETT. Mr. President, I yield myself such time as I may require.

Mr. President, I say to my friend from Minnesota, whose enthusiasm is one of the refreshing things about this place, that he need have no fear about voting for the Mitchell plan. Because I am convinced if the Mitchell plan passes, it will be such a disaster, bureaucratically and administratively, that his opportunity to take the opening to offer single payer will be hastened by the failure of the Mitchell plan. And there are some of us, frankly, who would prefer single payer to the disaster of the Mitchell plan. I say that as one who is opposed to single payer, but who, upon examining the Mitchell plan, says administratively single payer makes more sense.

Mr. WELLSTONE. Will the Senator yield for a moment?

Mr. BENNETT. I will be happy to yield.

Mr. WELLSTONE. I thank him for his remarks. I obviously do not agree with his analysis of the Mitchell plan, at least within the Senator's framework. We will not go into it now. But I am very interested in the second point he made. If that is the case—and I know the Senator from Utah to have tremendous intellectual integrity—then I am hoping that I will be able to enlist the Senator's support for at least some language that will enable the States to have flexibility to go forward with their different approaches.

In other words, that was one of the things, as I mentioned in my earlier remarks, which surprised me about the bill. And Senator DOMENICI, who is one of my best friends here, brought out language that would preclude States from being able to do that.

Why not let the States have an opportunity, and if it does not work, it does not work, but let the people and their representatives decide.

Mr. BENNETT. Mr. President, there are some reasons why we adopted the position we have, in our view. But I would be more than happy to sit down with my friend from Minnesota and go through that, because the main point I intend to make in this discussion that is coming up is that the notion that we are facing a window of opportunity here that will close within the next 20 days if we do not take it is a notion that is completely unacceptable to me.

I believe we will meet next year, we will meet the year after. I think we will be discussing this over a period of time, and what I am going to ask for is an intelligent, staged reform that does not rush to judgment or, in my view of the Mitchell bill, rush to disaster in the desire to meet an artificial deadline.

I would be happy to visit with my friend from Minnesota to talk about the place where a single-payer thing might be of some appropriateness, but do it in something other than the kind of frenzy that has been built up around this debate today.

Mr. President, I remember as a freshman Senator some months ago walking onto the floor and falling in step with the distinguished chairman of the Finance Committee, Senator MOYNIHAN. I first met Senator MOYNIHAN when we served together in the Nixon administration. Maybe neither one of us want to admit that now. But he served as domestic counselor to President Nixon, and I was in the Department of Transportation as the head of congressional relations. Ever since that time, I have had great respect for his intellect and his intellectual honesty.

As we stepped onto the floor of the Senate, I said to him, "Senator, are we going to get health care this year? Are we going to be able to pass something?" And he said, "Yes, I think so."

Then with his well-known understanding of history, he gave me the following history lesson:

He said, "Harry Truman tried to do it in the 1940's and the Republicans said no and we didn't get anything."

He said, "Richard Nixon tried to do it in the late 1960's and the Democrats said no and we didn't get anything. But now," he said, "both the Republicans and the Democrats are agreeing that we have to do something about the health care system, and I think we will get a bill."

That is what he was saying, and I was agreeing with him roughly a year, 14, 15 months ago.

Now, where are we today? I turn to the current issue of Newsweek under the head, "National Affairs," and read this headline: "Will Reform Bankrupt Us?"

Health care: 65 percent of Americans say Congress should start over. Newsweek's economics columnist argues that they're right.

How did we get here, from a circumstance where a Republican and a Democrat could walk onto the floor of the Senate agreeing with each other that we are going to get a bill, to the point where a national publication says 65 percent of the Americans say we should wait and start over next year and they argue very persuasively, in my view, that the 65 percent of Americans are right.

What has gone wrong with the process? Have we not discussed this enough? Oh, Heaven knows we have discussed it enough. We heard on the floor of the Senate about the 80 hearings that have been held in the two committees, and that is just in the Senate. We talked about it on the House side. We spent time on the floor. Yes, we talked it through enough. What is left to discuss?

Well, I suggest that we have talked and we have talked and we have talked about the wrong things. We missed some very fundamental points that need to be addressed before we are going to come up with the answer to this. I would like to outline some of those.

No. 1: We have not talked at all, except in a glancing occasional reference, about better health. We have spent all our time talking about health care, but we have not talked at all about providing information or motivation for people to stay well in the first place. Of course, the best cost containment of all in the health care debate is going to be better health on the part of individual Americans. This is not a matter of universal coverage; it is a matter of education and motivation.

We do it in other kinds of insurance. I see the ads, so do you, for auto insurance: "Nonsmokers discount," we see. There is a clear economic incentive for somebody to do something intelligent about their own health and stop smoking.

When I go down for a life insurance physical, the first question I am asked: "Do you smoke? Do you drink? Do you engage in—" and they have a list of other high-risk activities. And when I say, "No, I don't smoke; no, I don't drink," so on, "No, I don't engage in some of these other things," they say, "Well, you will get a better rate."

When we stand on the floor and talk inevitably and incessantly about health care for all Americans that cannot be taken away, we wipe aside the notion that there might be some kind of incentive that could be built into our system that says that people who take better care of themselves should get a better deal when it comes to paying for health care than people who do not. That has not been part of the debate, and that is one of the reasons why we have gone astray in all the talk we have had and missed the point.

If I may quote from the Newsweek article with respect to this issue about better health, Mr. Samuelson says:

We are slowly surrendering our economy to health care—for surprisingly modest gains in our health—and what we needed was a debate that confronted these relentless pressures. "The cost-control imperative has been lost," says John Inglehart, editor of the respected journal Health Affairs. Some day there may be frightful economic consequences. Business groups already say the costs of Government-dictated benefits will destroy jobs. Those would mount if health spending climbs and the costs are imposed on businesses by flat or payroll taxes. Europe's experience is sobering. Since 1974, its unemployment has risen from 3 to 11 percent and private job growth has been meager.

His first point, we have seen all this increase in health spending, but we have gotten very little benefit and results.

Here is the same article:

Economist Charles Phelps of the University of Rochester studied the connection between higher health spending and Nations' improved health. The connection was "tenuous." The biggest health gains come from higher incomes—

If you earn more, presumably you take better care of yourself, not from health care,

higher incomes, better education and inexpensive measures: Vaccinations, antibiotics against infections. Among individuals, diet and personal behavior (smoking, drinking, drug use) often explain who's healthy and who isn't. Even in societies such as England and Sweden, where everyone has insurance, the poor aren't as healthy as the middle classes.

You have not eliminated the disparity in health by eliminating the disparity in health coverage, and that is something I think we should have been talking about.

I keep hearing from my constituents: "As you address health care, Senator, address the issue of high-risk behavior and do something to see to it that there is some kind of economic incentive for people to take better care of

themselves." But there is nothing in any of these bills, there has been nothing in any of the hearings that has addressed that issue.

No. 2: In all of the hearings we have had and all the discussions we have had, we have not, in my view, had a serious discussion of the importance of why market forces do not really work in health care.

I have already given a speech on this. I will not repeat it all. But let me summarize it.

First, the basic principle. When it comes to allocating scarce resources, market forces are always more efficient and fairer than Government's. That is a truth that has been established since the days of the ancient Egyptians and Romans, and on through the Renaissance and all through the Industrial Age.

Write it down. You can take it to the bank. When it comes to allocating scarce resources, market forces are always more efficient and fairer than Government's. So we are talking about allocating health resources and market forces do not work. Why do they not work? For one very fundamental reason. The customer has no power in the health care debate. The customer does not control what will happen. Who does? The insurance company. The insurance company is the controller, not the person who is consuming the health care.

I had that brought home to me very vividly during the campaign. I went to a hospital in Ogden, UT, the standard campaign circumstance. I was going through talking to people. I sat down in the boardroom with the administrators of the hospital, and we began talking about some of their problems.

They were commenting that the equipment in their hospital—I do now know whether it was an MRI machine, but let us take that as an example because everybody is talking about too many MRI's in the United States. This piece of equipment in their hospital was utilized about 20 percent of the time.

Well, being a businessman, I immediately said to myself the market is telling you something, hospital administrator. The market is telling you there is no more demand than 20 percent for that machine. You ought to do something to make a deal with the hospital down the street so that you could say, well, we are going to refer everybody who needs an MRI to the hospital down the street, and we will get full utilization of this machine.

My mind is saying we have to do something in Congress about the antitrust laws so the two hospitals can do that; they can talk to each other.

"No, no," they said. "Mr. BENNETT, you do not understand. We have this MRI in this hospital because the market insists on it."

And I say, "Now, wait a minute. You do not understand. With a 20 percent utilization, the market is sending you a message."

They said, "No. You do not understand. We have to have it in order to meet the market."

We stood there and argued back and forth fruitlessly for 4 or 5 minutes until suddenly they enlightened me as to what they were talking about when they said the "market." They said, "If we do not have an MRI machine in our hospital, insurance companies will not allow any of the people that they insure to come to our hospital."

I said, "Oh, wait a minute. You are telling me then that the market is the insurance company, not the sick person."

They looked at me like I was the dumbest guy in the block. "Of course, the market is the insurance company. You think we exist to serve sick people? We exist to serve insurance companies who send us sick people. And the insurance companies say we will not send anybody to your hospital unless you have an MRI, so we have to go out and buy an MRI, even if we do not get enough utilization for it and we have to cost shift."

The light began to go on in my head. Market forces do not work in health care because the consumer is not the customer, and we need to do something about that. But we have not had that point raised in any of these hearings. We have not talked about it in these hearings.

So someone else is making the economic decision for me as the consumer. And who is the someone else? Ultimately, it is the employer. Now, I have been an employer. I have been the CEO of a company. I have made the decision. I have had everybody come in. They make the presentation to me. I am the CEO. I get to decide. The insurance companies are coming to me. The self-insurance regulators are coming to me. The HMO's are coming to me: We want to sell your employees this thing. But really they want to sell me. I make the decision for all my employees.

What kind of market force is that, if one of my employees wants something other than I decide he or she should have?

We perpetuate this in this whole debate. We have never challenged that. We have gone willy-nilly from the notion that the employer should decide what people should have, to the idea that the Government should replace the employer deciding what people should have. And never in the debate have we raised the issue that maybe the people should decide what the people should have, at which point you begin to get market forces coming into the circumstance.

All that these various bills we have before us do is substitute the Government for the employer and leave the underlying problem still in place. We are never going to get true cost containment until we do something about that No. 3.

Never have I heard in all these hearings anybody challenge the absurdity of the notion of first-dollar coverage. Once again, let us look at insurance outside of health care and see how absurd this notion is.

Auto insurance. We all have auto insurance. Talk about mandates. We are mandated to have auto insurance in my State, and I assume every other State. I cannot get a driver's license; I cannot get a license for my car renewed if I do not have auto insurance. It is checked every year when I go in to get it renewed. There is a very firm mandate.

But my auto insurance does not provide first-dollar coverage. It would be absurd for me to think of it. What would it cost for an auto insurance plan that says we will cover through our insurance coverage the cost of changing the oil in your car. It cost me about, if I go to one of these Jiffy Lubes, $19.95 to change the oil and the oil filter in my car.

Suppose, along with the cost of changing the oil and the oil filter, I had to pay the cost of filling out an insurance form and sending it to a third party to scrutinize it to see whether it came under the terms of my policy, and then the insurance company would pay for changing the oil.

I rather suspect, based on various studies that have been made in the health insurance industry, that the cost of handling that insurance claim would be around $20. So what does that mean for the cost of changing my oil? Instead of $20, it is going to be $40. What kind of premium am I going to have to pay for that policy in order to have the insurance company pay for the changing of the oil?

Very quickly, I can put a pencil to it and say it is a whole lot cheaper for me to have an auto insurance policy that pays for catastrophic events like if I run into somebody in an intersection and get sued. But, frankly, I will pay for changing the oil myself.

The same thing in homeowner's insurance. What kind of homeowner's insurance policy would we have if the policy covered the cost of mowing the lawn? It is so absurd nobody even thinks about it. And yet in health care we have it in our heads that somehow, if the insurance is not there to pay for changing the oil in the car, or is not there to pay for the cost of mowing the lawn, then we are not covered.

It is the absurdity of the notion of first-dollar coverage that is driving the cost of medical insurance right through the roof. We need to change our thinking and start saying the insurance principle should be what it has always been in everything else, which is insurance covers catastrophic events and it is not there to pay for a $15, $20 office visit by adding a $15, $20 claim cost on top of the office visit.

No. 4—and it comes out of No. 3—the myth of other people's money. I have heard this on the floor today, and this again is something we have not talked about in this whole debate. The idea that you are paying for your health care with somebody else's money, the employer must pay for my coverage, somebody else's money, is nonsense. Actually, it is all your money.

We have had percentages kicked around. The original bill that we were thinking about that has been the subject of hearings says that 80 percent of the costs will be paid by the employer. We are going to have a mandate that says every employer has to pay 80 percent of the cost. No. There is a flashback against that. So along comes Senator MITCHELL. He says: I recognize that I cannot get an 80-percent mandate. I will go for a 50-percent mandate. So the employer will only pay 50 percent.

I am sure my friend from Minnesota would complain about that and say it ought to go back up to 80 percent. We just heard him say the Federal Government pays 79 percent of ours. Why should not every employer pay 79 or 80 percent? I would say to my friend from Minnesota, if he were here, that the Federal Government does not pay 79 percent. Employers do not pay 80 percent. I pay 100 percent. Every dime that goes for my health care is a form of compensation to me, and in the private sector particularly it represents a lowering of my taxable income by virtue of an employer decision to put the money in health care benefits instead of in my paycheck.

There is no such thing as other people's money here. It is the employee's money in every case. Again, I have been an employer. I know how it works. I explain to my employees, you may think you have a $20,000 a year job, but it is a $30,000 a year job because that is what it is costing me as your employer. I have to pay $30,000 to keep you working for me. I put $20,000 of that on your W–2 form that you take home at the end of the year that you pay taxes on. I put the other $10,000 into a variety of benefits for you. But they are still going to be part of the cost of having you on my payroll.

Indeed, we have heard some of the ads that have been running during this debate that make reference to that. Somebody says, "Hey, I want those benefits. I gave up wage increases to get those benefits." You have heard that on some of the commercials. That employee is beginning to understand that those are his dollars, not the employer's dollars. One hundred percent of the cost of health care falls upon the employee, because the employee is earning enough money for the employer to pay that $30,000 that I referred to in the example, not just the $20,000 he takes home.

So when Senators stand up on this floor and say, "If the Senate of the United States does not pass this health care legislation, I will move to take away their benefits," all he is really saying is, "I will move to cut their salary, cut their compensation, by the amount those benefits represent in dollars."

What will I do if that passes? I will do the same thing every other Member of this body will do. Having taken about a $300 a month salary cut, I will take the money that is left and go out and buy myself some coverage someplace else. The Government does not give me benefits. The Government spends my money for benefits which the Government has decided I need.

So, as I say, these two come out of each other, the myth of other people's money and the earlier point about the lack of market forces operating in health care.

So, Mr. President, I suggest these four things have been missing in this debate in spite of the debate's length and complexity:

No. 1, we have not discussed the impact of this whole thing on people's health, and what it will do to make them healthy.

We have, No. 2, not discussed the failure of true market forces to work.

No. 3, we have not discussed the impact of the absurdity of the notion of first-dollar coverage on health care.

And, No. 4, we have not discussed the impact of the myth of other people's money.

I think we need to do that if we are truly going to restructure the health care system around sound principles.

The end result of all of this, our failure to discuss these underlying points, is summarized again in Newsweek. I go back to the article and give you a few observations.

President Clinton is right about the historic opportunity, and he blew it. Somewhere along the way, health care took a decisive turn towards fantasy.

I agree with that completely.

If Congress passes sweeping health reform, as they urge, we will have compounded all our long-term budget and economic problems by force-feeding the monster of health care spending.

I agree with that completely.

We are headed in the wrong direction. We need to stop and start over again. We are left with a legislative mishmash of ideas cobbled together in the majority leader's office in the last few weeks, put into legislative language that has now been revised twice. So that we have three sets of ideas before us, under an enormous time pressure, pushed onto the floor with an artificial deadline, with no report language, no opportunity for a careful analysis of all of it, no chance to run some of these things by real-life scenarios before we have to vote.

And in the pressure cooker of floor debate, with the threat of a cloture vote designed to embarrass people politically hanging over us, we are told to legislate the most far-reaching piece of social engineering ever proposed since the Great Depression.

Mr. President, that kind of demand upon the Senate is irresponsible; it is dangerous and it is unnecessary. I say it is irresponsible because we are left with a bill that few, if any, have read—I tried, only to have to stop when the next version comes out and start all over again—a bill few understand, and no staff has really been able to summarize it or synthesize it to my satisfaction.

With respect to "one-seventh" of the economy, that statement has been made. I put it into chart form. For the sake of helping us understand just how big it is, we show here on the top line, the red line, the total U.S. health industry economic activity, which is $942 billion. That is a big number, by anybody's imagination.

But let us put it in some kind of context. How big is that? Is it bigger than a bread box, to go back to a phrase that comes out of my youth, on television? Is it bigger than the entire economy of Great Britain? This first yellow line shows the entire economy of the United Kingdom. Do you think that people in the Parliament would be restructuring their entire economy in a single bill in a single Congress, and be considered responsible? No. They would go about something like that very carefully.

Canada—here is the entire size of the Canadian economy. We are talking about nearly twice as much money as the entire Canadian GDP; Spain, The Netherlands, Australia, Belgium, Sweden, Austria, so on and so forth, all the way down. There are only five nations that have GDP's larger than the amount of money that we are talking about. They are Italy, France, Germany, Japan, and of course, the United States, because this represents one-seventh of our GDP. So our total GDP would be seven times bigger than this.

This illustrates the size of the stakes that we are playing with here. It is irresponsible, as I say, to be dealing with something that big in the manner in which we are.

I said that the bill was complicated. The bill is huge. It is almost impossible for anybody to understand it, including the staffs.

There is one group that probably understands it about as well as anybody, and are forced to by virtue of their profession and assignment; I am talking about the Congressional Budget Office. The Congressional Budget Office, after looking at how we would restructure $942 billion worth of economic activity, has this to say:

For the proposed system to function effectively, new data would have to be collected, new procedures and administrative mechanisms developed, and new institutions and administrative capabilities created.

That is a pretty daunting task all by itself.

In preparing the quantitative estimates presented in this assessment, the Congressional Budget Office has assumed—

They have not determined; they have assumed.

not only that all those things could be done, but also that they could be accomplished in the timeframe laid out in the proposal.

Those are two rather significant assumptions. And then in what I consider one of the great understatements in the document, they say:

There is a significant chance that the substantial ranges required by this proposal could not be achieved as assumed.

We are fooling around with something bigger than the entire GDP of Great Britain, and there is a significant chance that the underlying assumptions could not be reached.

What are the implications of this kind of haste to judgment, having, as I said, ignored some of the other things that are outside our normal view of the way this matter should be discussed? I think it is dangerous for us to proceed, because the first indications we have of what will happen can be very, very serious.

Going back to the Congressional Budget Office, it says:

The subsidies for people who are temporarily unemployed would be particularly hard to administrate and monitor. It would be difficult, for example, to determine whether people had left their jobs voluntarily or involuntarily, or whether they would receive employer contributions for health insurance through an employed spouse. Moreover, because of the way these subsidies would be structured, significant horizontal inequities could result. That is, families with similar income could receive quite different subsidy amounts.

Senator Mitchell's proposal, like many other reform bills, would encourage a reallocation of workers among firms in ways that would increase its budgetary costs. In addition to raising the Government's costs, the reallocation of workers could reduce the efficiency of the labor market.

Again, the ripple effect of bad decisions as it goes through the entire economy.

The imposition of the mandate would raise the cost of employing workers at firms that do not currently provide insurance. Economic theory and empirical research both imply that most of this increased cost would be passed back to workers, over time, in the form of lower take-home wages. Such shifting would not be possible, however, for workers whose wages were close to the federally regulated minimum wage. Therefore, the net cost of employing those workers would be raised by the mandate, and some of them would lose their jobs.

Let me pause with a definition that does not come out of Webster's. I take full responsibility and blame for it. But I say here that my definition of a mandate that forces people to spend money is that it is "a tax." If you mandate something that causes people to increase their costs, it has exactly the same impact on the business as if you had raised their taxes. And we are talking about a whole bunch of mandates here. "Oh, no," we are told, "the Mitchell bill does not have any mandates." Oh, yes, it does.

The Mitchell mandates. Who gets hit? Or if I apply my definition, who gets taxed? There is a mandate on future Congresses. This bill tells future Congresses what they must do if certain things do not happen.

There is clearly a mandate on States. Clearly, there are requirements that the States are going to have to spend money—mandates on doctors, health care providers, big businesses, small businesses, independent contractors, individuals.

If the trigger kicks in, clearly there will be mandates all the way through. Who pays? Well, of course, as I said earlier, ultimately the individual pays all of these costs in the form of higher taxes, lower wages, fewer jobs, lower quality, and less choice.

The Mitchell mandates are clearly in the bill.

What will happen if the Mitchell bill passes? In my view, there are a number of things that can be fairly safely postulated. No. 1—and we have talked about it—costs will rise.

If I may turn to an article that appeared in the Wall Street Journal, written by Martin Feldstein, former Chairman of the President's Council of Economic Advisers, currently a professor of economics at Harvard. He is talking about mandates in much the same way I am. This an article entitled "The Hidden $100 Billion Tax Increase." I will repeat that: "The Hidden $100 Billion Tax Increase."

Professor Feldstein says:

President Clinton is increasing the pressure on Congress to enact a massive and irreversible entitlement program to subsidize health insurance and redistribute income. The cost for this largest-ever welfare expansion would top $100 billion a year at today's prices. That is equivalent to raising personal taxes across the board by nearly 20 percent.

Amazingly, the Senate Democratic leadership has managed to conceal this massive tax increase from the public. The legislative wrangling and public discussion have virtually ignored the cost of financing this spending explosion. Members of the business community have been so eager to avoid employer mandates that they have not considered the tax consequences of the pending legislation, and members of the general public have been so concerned about preserving their ability to choose their own doctors that they have not focused on what these plans would mean for their individual wallets.

In short, buried in the CBO numbers is the projection that the Senate Finance Committee plan would have a $63 billion annual cost, at 1994 price levels, and that all but what the CBO estimates to be $14 billion in cigarette levies would be obtained by hidden taxes in the form of cost shifting through health care providers and insurance companies. It's remarkable that the same politicians who have produced this $49 billion in hidden cost shifting have the audacity to say that the public should support their plan in order to eliminate the much more limited cost shifting that occurs under the existing system as hospitals pass on the cost of free care.

Indeed to the extent hospitals are already giving free care, the increase in formal insurance coverage gives that much less to the currently uninsured and confirms that most of the plan's cost is to achieve income redistribution, not expanded health insurance. Costs will rise, and the historic driving force primarily responsible for people being uninsured is high costs.

There are those who suggest, even if the press reports can be believed from Mrs. Clinton herself, that one of the main consequences of passing the Mitchell bill will be to increase the number of the uninsured. I think the fact that the costs will rise is a driving force behind that belief.

People in America are not stupid. They can figure out how to game a system. It is very clear that they will start to game this system. They will split into several companies with under 25 employees in each company. They will hire more temps. That is already happening. We see that phenomenon, clearly, through the economy. And it is cheaper for an employer to pay overtime than it is to pay benefits to a second employee when the benefits have been mandated at such a high level. We are seeing that happen in the economy now.

The community rating experience in New York shows that the number of uninsured raises and does not fall under the community rating system unless, once again, there is a very heavy-handed force that comes in and the Government gets involved more and more and more.

The net effect is that the number of uninsured will go up rather than come down. In my view, it is an absolute certainty that the Mitchell bill will fail to decrease the percentage of the uninsured so that we are certain that if we pass the Mitchell bill we are legislating for the Congress in the year 2002.

The trigger is not a hard trigger. It is not a soft trigger. It is, in fact, a certainty. The Mitchell bill will not work, and the trigger called for in the Mitchell bill will take place. That is inevitable.

So we find ourselves in the circumstance of being arrogant enough to say that this Congress, in the name of going through a window of opportunity that we are told will not reappear for another 30 years, has the wisdom to shape the form of health insurance and health coverage for this country 8 years from now, and that intervening Congresses will be frozen out of doing anything about it.

Well, the absurdity of this is what is causing the rising chorus of dissatisfaction within this Congress, House and Senate. We are getting new bills introduced all the time. I just agreed to go on one, along with my friend, Senator DOMENICI, on the Republican side; and it will be sponsored on the Democratic

side by Senator NUNN and Senator BOREN. It will be along the lines of the bipartisan effort that is being introduced in the House. We will have formal introduction of it sometime early next week.

There is rising dissatisfaction with the options in front of us, a sense that somehow Mr. Samuelson is right. We have missed a historic opportunity. The debate has taken a decisive turn toward fantasy, and we probably ought to start over again next year.

I will say that I do not think we should despair of doing anything in this Congress. I would not be, along with the three Senators I have mentioned, sponsoring a new bill at this late point if I felt that way. We can do something this year. We can do something meaningful this year. We should just make sure we do not do something dangerous or irresponsible this year.

My friend from Minnesota gets all upset because the bill we are sponsoring does not provide universal coverage, and I say to him that he is absolutely right, and it is not designed to. But it is offered on the assumption that the Congress will meet next January. It is offered on the assumption that the Finance Committee will still be in business next year and can address the issues that I have talked about in something less than the pressure cooker we are in—can go back to the fundamentals that have been overlooked, that I mentioned in the beginning of my statement, and try to sift through those. And, in the meantime, we will have at least this year taken some steps to solve the problems we all agree should be solved.

I reject the notion that seems to underlie most of this debate that says if we do not do it in this Congress, we will not get another shot for 30 years. I had that exchange with Dr. Uwe Reinhardt when he appeared before the Joint Economic Committee and said, "Why can't we do it intelligently, one step at a time, and do what we now know we have to do and tackle some of the structural things next year?" He said, in effect, "Senator, that is clearly the right way to do it. But those of us who are junkies on this issue say that we get one opportunity every 30 years, and this is our only opportunity."

I said, "That is stupid," and he looked at me and he said: "Are you willing to commit to addressing this next year?" And I said, "Not only next year, but the year after and the year after, and however long it takes to try to get this thing solved."

He kind of blinked a little and said, "Well, if the Congress really would do that, maybe we do not have to do it all this fall."

So that is my plea. Let us abandon the imagery that comes out of the space program of a window of opportunity. In the space program—you will recall that is where the phrase came from—there is a window of opportunity in space when the weather and the placing of the moon and other things relating to a launch opens up, and it is open for a matter of a few hours, and then the moon moves on or the weather rolls in and the window closes. And the people at the Johnson Space Center in Houston realize it is going to be x number of months before they get another window. That is where the phrase comes from, and that is the imagery we have been going on that has been driving the debate.

Let us set that imagery aside and replace it with the understanding that President Clinton has, instead of pointing out a window of opportunity, given us an open door to walk out of the past, into an open, sunlit circumstance, where we can view all our options and make intelligent decisions, and the window will not close once. We are through that door, on the other side, committed to the idea of doing the right thing for health care. We can do it intelligently, gathering the data, waiting until we see what the data tells us before we take the next step, then watching to see what happens, and moving intelligently and soundly in the direction of solving this problem ultimately for all of our citizens.

Am I committed to the idea of universal coverage? If you will let me define what universal coverage is, I will tell you absolutely I am committed to the idea of universal coverage. Am I agreeing with the idea that we are rich enough to provide the proper kind of health care for every American? Absolutely, I agree with that. But I do not want to do it under an artificial deadline, working with a legislative mishmash that has been put together in a political atmosphere of debate that has ignored some of the very basic concepts that I have been talking about.

Back to my imagery. President Clinton has opened the door. I give him full credit for that. I always have. He has had the courage to take on an issue that many of his predecessors ducked. But we are walking into that sunlight on the other side of the door with blinders on, blinders that come out of the paradigm, if you will, that we have lived on this side of the wall, and we need to take the blinders off and look around. And we are not going to be able to do it in the present legislative circumstance.

That is why I say the folks in Newsweek have it right. Sixty-five percent of Americans have it right. We should not rush to judgment on this.

I conclude by quoting once again from the Samuelson argument. He says:

> What we have had this year was the chance to begin grappling with the basic questions. We squandered it. The Clintons imagined that health care will secure their place in history, and in a peculiar way, they may be right. History is written with hindsight, and when it is, it may judge them harshly, not simply because they led us in the wrong direction, but because all the evidence needed to go in the right direction was obvious, and they chose to ignore it.

Mr. President, I yield the floor.

The PRESIDING OFFICER (Mr. DASCHLE.) The Senator from New York.

Mr. MOYNIHAN. Mr. President, may I once again take this opportunity, as I have not had it sufficiently, to thank the Senator from Utah for his very thoughtful, important statement. And that statement we have been hearing from both sides of the aisle today. Universal coverage is a goal that this country can achieve and ought to commit to, and will, I think, do both.

That was a very fine statement.

Mr. BENNETT. Mr. President, may I thank my friend from New York for his kind remarks, and in the spirit of what he has just said, remind him of my opening statement. I do not think he was here when I made my opening statement. I quoted him, I hope correctly, at a time when he and I walked onto the Senate floor and I asked him, as a freshman at the feet of the experienced legislator, "Are we going to have health care this year?" And he said to me—he may well have forgotten, and he may now wish to repudiate the notion—but he said to me: "Harry Truman tried it in the 1940's, and the Republicans said 'No.' Richard Nixon tried it in the late 1960's, and the Democrats said 'No.' Now we have both Republicans and Democrats agreeing that it ought to be done, and I think we will get a bill."

If we can go back to the spirit of the Senator's comment to me there, I think we can get a bill, and certainly over time we can solve the problem.

I think it is very significant that every single Republican Member of this body has signed on to some kind of bill calling for basic restructuring of the health care system, and certainly the same is true on the Democratic side. That is a matrix that has not existed in previous growing seasons, and I hope we do not lose it this time.

Mr. MOYNIHAN. I thank the Senator.

And that is the extraordinary central fact of this debate.

Mr. President, the fact that this debate is taking place, the fact that we are here on the floor speaking about universal coverage with such a wide convergence of views on that essential principle, is owing, in more than any one thing, to the extraordinary efforts of the Senator from Pennsylvania.

He raised this issue in the most dramatic way almost 4 years ago in his State in that election. His success rang a bell that is still echoing across this Nation.

He has to leave for Pennsylvania, so his good friend and mine, the Senator from Michigan, has agreed to step aside for a moment.

I ask unanimous consent that the Senator from Pennsylvania be recognized for 15 minutes, followed by the Senator from Michigan.

But, once again, I state my great gratitude. We are indebted to you, sir.

The PRESIDING OFFICER. The Senator from Pennsylvania is recognized.

Did the Senator from New York yield to the Senator from Pennsylvania?

Mr. MOYNIHAN. I do so.

Mr. LEVIN. If the Senator from Pennsylvania will yield, was the unanimous consent of the Senator from New York granted that after the Senator from Pennsylvania is finished, that I then be recognized for 15 minutes?

The PRESIDING OFFICER. Is there objection? Hearing none, it is so ordered.

Mr. WOFFORD. I thank the Chair.

Mr. President, for the last couple of hours, I have been talking to 100 or more people from around Pennsylvania. And there was a great contrast between the clarity with which they saw some of these issues and the lack of clarity and confusion that we have had during part of this debate.

But I want to thank the Senator from Utah for the spirit in which he ended and he began his remarks. I take issue with some of the points in between, but we must find a way not to lose this opportunity. And it is not going to be all done this year. We will be back next year and the year after that.

One of the things I do agree with him on is that we should not focus entirely on an action or a trigger that takes place in the year 2000 and moves into the next century. I certainly do not think any of us should be proud that we are seeking to stretch it out, delay it, move beyond the next century. I hope very much, in addition to whatever happens in the year 2000, to see how far we have come on the way to universal coverage; that every year, once we have set up a health insurance structure charting the way to universal coverage, that every year we have an annual checkup in which we see how far we have gone and how far we have fallen short.

A doctor does not say, "Let's try aspirin, or this little medicine for a while and come back in 6 years." A doctor says, "Call me in the morning."

I think our national health commission, as soon as it comes into being, should report every year on how far we have moved toward coverage or slipped back, whether more employers are contributing or less, whether the burden is being shifted more onto the backs of families and individuals and working people—an annual checkup. And I hope the Senator from Utah will join me and our Presiding Officer and others of us who want to see that there is an annual checkup and a report to the Congress and the people so we can take action sooner rather than later.

I hope that on every key element of this bill we strive for the principle of sooner rather than later. For example, we should look at every element that takes no additional cost but could go into place now—the ending of the preexisting condition rule that excludes people when they change jobs, when they move; a condition my wife has that made her scared that if I lost my job we could not get health insurance, really scared at a time before she was old enough to qualify for Medicare. That rule ought to go on day one. It ought to go next year. That insecurity should be lifted. The shadow of death should be lifted from the people who have a preexisting condition.

And Senator DODD's amendment that is before us now, for children first, for something that, in basic private health insurance plans, preventive care for children and for pregnant women, comes into place sooner, not later; not the year 2000. Sooner rather than later.

But there have been so many myths and misrepresentations and my friends from Pennsylvania were seeing through them so clearly just a little while ago. A lot of them came from Washington, PA. And the contrast between how they understood it from Washington, PA and how some of my colleagues here understand it in Washington, DC was very stark and disappointing.

There were some of them that go back to Harry Truman, too. There was a man that was at Keesler Field, MS, in the Army Air Corps in World War II when I was there. He was out there telling me that he, like I, was there cheering Harry Truman on when he started the battle for universal health insurance.

Some of us in that crowd remember the studies and the hearings and the proposals and the care that went into trying to craft a good plan then, and the special interests and the fog of confusion that was laid down that beat Harry Truman.

There were a lot of people there that remember when President Nixon, aided by the Senator from New York—then not a Senator from New York—when the chairman of the Finance Committee, in a previous incarnation, helped President Nixon present a plan to us, a careful, thought-out plan, and we did not take that opportunity. A terrible lost opportunity then.

Others have heard the Senator from Massachusetts, the chairman of the Labor and Human Resources Committee, over the years, over decades, conduct hearings, present plans.

The Senator from West Virginia, Senator ROCKEFELLER, has been part of some of the most remarkable hearings as part of the Pepper Commission. A mountain of studies have piled up. And my friends from Washington, PA, know in their bones it is not more study that we need.

I have been in the Senate for 3 years. From the day I got here, I have been part of efforts—some of which I have pressed for and some of which my colleagues, who have been in this battle before I got here, were already planning—week after week, hearings, careful proposals, homework. In the Labor Committee, 151 hearings. In the Finance Committee, I think it is 32 hearings; the Veterans' Committee, and other hearings just in this body alone.

We are talking about the bill that has been crafted by the majority leader—the bill that drew on the careful work of the Finance Committee and the Labor Committee and blended those proposals together in a bill that is before us—as too complicated, too long, too heavy a document.

Well, I once on this floor assembled all of the NAFTA documents. I think there were five, it may have been six, volumes. They piled up this high. This Congress knew how to act on that. I did not go along with the way they acted. I opposed it. But it was not too complicated to pass that NAFTA bill. And now we hear this is too complicated.

Well, my friends from Pennsylvania, they have a very simple test. I agree with them. But it is a test that came out of the people of Pennsylvania. And that is, what is good for Congress ought to be good for the American people.

They do not understand why a Congress that has arranged for itself guaranteed health insurance—cannot be canceled, no preexisting conditions, comprehensive benefits, a choice of private plans, not Government-run plans, but Blue Cross-Blue Shield, HMO's, your own plans, choose your own doctor—why Congress can arrange that for themselves and for 9 million Federal employees and their families, with their employer contributing three-quarters of the premiums, why it cannot now move forward, after all this work in this Congress, to take the great step forward in arranging that kind of a private health insurance for the American people.

I think the people in Pennsylvania, through this confusing debate, have gotten the point. This is not new Government-run medicine. It is private health insurance. They have seen the charts that have been put up. I do not know what that chart really is about, but a far more complicated chart would be the chart of our present health insurance system. The doctor from Iowa has charted what the experience is for him. My wife tells me all the time what the paperwork and bureaucracy and back and forth and claims forms, the burden she carries as a patient, is like for her.

One day I was a billing clerk in Jefferson University Hospital. I do workdays in other kinds of work, closer to what people in Washington, PA, do than what we do in Washington, DC. One of those workdays was in a hospital. First, I was an admissions clerk.

I have seen admissions in a lot of hospitals, and there is this appalling experience of following somebody in a stretcher into the operating room saying, "How are you going to pay for it? What's your Social Security number?" Filling out the beginning of the forms.

And then I spent some hours as a billing clerk with the piles of bills, 9 months old, inch-and-a-half files, not just going back and forth with the Government, but with Blue Cross-Blue Shield, Aetna, Prudential, private insurance, dealing with 1,250 different plans and all the different forms. How in the world can the billing clerks figure out how to translate the doctor's notes into a bill? They do not succeed. The plans send it back saying, "You did not fill it out right, our categories are different from the Blue Cross or Medicare plan."

All those different forms. If we cannot have a simple claims form, simple standard system, simple information system—it does not have to be Government run. We put an amendment in the Labor Committee and the Finance Committee, that I pressed for and sponsored, which drew on the work from Senator BOND on the other side of the aisle and Senator RIEGLE on this side, that says the private sector can do the information system with standard measures.

Finally, I want to say the people in Pennsylvania see through to the central point. If Members of Congress can arrange it for themselves but do not believe it is time to have it for the American people, then get off the Government trough, get off the present plan that enables them to be shielded from the experience that the American people have, cease enjoying this Federal benefit plan with guaranteed insurance.

If they want to study it more—if they succeed in persuading us not to act now—if they want to study it more, then study it on a level playing field with those American people whose employer does not contribute and see what it is like to get health insurance in the private market.

I say practice what you preach. If you really believe that should not be what is possible for the American people, then do not require it of your employer, the taxpayers of the United States. And if you want more study, then study it while you feel some of the heat and some of the hurt that the American people are feeling while we delay.

They know, the people I have just been meeting with, just like justice delayed is justice denied, health care reform delayed is health care denied.

Mr. MOYNIHAN. Mr. President, may I congratulate the Senator from Pennsylvania once again. As I keep track, every day of this debate he has stood up, added to the debate, and concluded with that point: Health care delayed is health care denied. It is unmistakable fact. We are deeply in his debt for keeping it before our eyes.

Mr. President, I yield to the Senator from Michigan.

The PRESIDING OFFICER. The Senator from Michigan is recognized.

Mr. LEVIN. Mr. President, first, let me add my voice of thanks to the Senator from Pennsylvania in what he has done for this Nation, bringing this issue so dramatically to the Congress as he has in recent years. His being on the floor so constantly and his raising the issue of the importance, of the time urgency of this issue is a little bit reminiscent of a Senator from Wisconsin who used to be on the floor, I think, every day on the Genocide Convention, for year after year.

Mr. MOYNIHAN. Senator Proxmire.

Mr. LEVIN. Decade after decade, until finally this Senate ratified the Genocide Treaty.

We see in the Senator from Pennsylvania the same kind of tenacity. We are going to get universal health care or he will be up here every single day of his career here reminding us that we have that obligation.

Congress is famous for not being able to act quickly and expeditiously to meet some of the important problems of the day. But I have to tell you, when it comes to health care I think we are setting a new world's record. This is 50 years. We are told we are rushing to judgment? Fifty years ago, almost, Harry Truman sent messages to the Congress—I have them here and I am going to read from them in a minute—urging the Congress to adopt universal health care. We have been told how many hundreds of hearings we have had in our various committees, and we have, under the chairmanship of Senator MOYNIHAN—I do not know how many hearings the Finance Committee has had. I do not know how many hearings Senator KENNEDY's committee had. Together they total over 100 in the last 2 years alone.

But this goes back for decades. This is an all-time record we are setting here for nonaction if we delay this again.

Harry Truman sent up a message to the Congress in 1945. It was called Special Message To The Congress Recommending a Comprehensive Health Program. It was a Special message to the Congress, November 19, 1945, espousing the right to adequate medical care and saying the following:

Millions of our citizens do not now have a full measure of opportunity to achieve and enjoy good health. Millions do not now have protection or security against the economic effects of sickness. The time has arrived for action to help them attain that opportunity and that protection.

"The time has arrived for action," that is 1945. He went on to say in his message:

We should resolve now that the health of this Nation is a national concern; that financial barriers in the way of attaining health shall be removed; that the health of all [all—all] its citizens deserves the help of all the Nation.

That message went on to say:

The American people are the most insurance minded people in the world. They will not be frightened off from health insurance because some people have misnamed it socialized medicine.

This is President Truman speaking:

I repeat, what I am recommending is not socialized medicine.

He went on to tell the Congress.

Socialized medicine means that all doctors work as employees of Government. The American people want no such system. No such system is here proposed.

He could be writing in 1994.

Under the Plan I suggest, [President Truman said] our people would continue to get medical and hospital services just as they do now on the basis of their own voluntary decisions and choices. Our doctors and hospitals would continue to deal with disease with the same professional freedom as now. There would, however, be this all important difference. Whether or not patients get the services they need would not depend on how much they can afford to pay at the time.

I am in favor [he wrote] of the broadest possible coverage for this insurance system. I believe that all persons who work for a living, and their dependents, should be covered by such an insurance plan.

He wrote another message to the Congress. That was not the only message that President Truman sent to Congress. He kept trying and trying, too, just like HARRIS WOFFORD.

The truth is [Harry Truman wrote] that all except the rich may at some time be struck by illness which requires care and services they cannot afford. Countless families who are entirely self-supporting in every other respect cannot meet the expense of serious illness.

Although the individual or even small groups of individuals cannot successfully or economically plan to meet the cost of illness, large groups of people can do so.

And the President wrote to Congress back then, in May 1947 when this message was sent:

If the financial risk of illness is spread among all our people, no one person is overburdened. More important, if the cost is spread in this manner, more persons can see their doctors and will see them earlier. This goal can be reached only—

President Truman wrote—

only through a national medical insurance program under which all people who are covered by an insurance fund are entitled to necessary medical, hospital and related services.

Fifty years later almost, we are moving in the wrong direction. We are actually seeing more and more people who are becoming uninsured. We are actually losing about one-half million people a year now from insurance coverage. So that about every 2 years, a million more Americans are losing health insurance. These are people who change jobs or now become ill or have someone in their family who has become ill, who are dropped from insurance, who become unemployed and, as

has been pointed out so many times on this floor and it is so poignant and so dramatic, the great bulk of our uninsured 40 million Americans are working people.

If you are on welfare in America, you are insured. You have health insurance if you are on welfare. If you work in America—if you work in America—you may or may not have health insurance. There is something wrong with that system, and we have to change it.

We actually now have about 17 percent of Americans, most of them working, who do not have health coverage, and about 6 million children without health coverage. Fourteen years ago that figure was only 12 percent. So that in the last 14 years, the number of uninsured Americans, the vast majority of whom are working people, has grown from 12 percent of our population to 17 percent of our population

Under the existing rules, many people lose insurance when they become sick. They lose insurance when they change jobs. They lose insurance if a family member becomes ill or if a family member loses a job. Forty-six Americans lose health insurance every minute in America.

At the same time this is happening, and partly because of it, health care costs rise at the rate of 10 percent per year, way above the rate of inflation; $1 of every $7 of our economy goes to health care. The average family spent more than $5,000 on health care in 1993, three times what they spent in 1980, and the situation worsens.

Without reform of our health care system, the Commerce Department estimates that by the end of the century the average family will be spending $10,000 each year.

As we debate details—and details are important and they are worth debating—but as we debate the details of the various plans before us—so far the Mitchell plan and the Dole plan basically—we should remain focused on the principal goal, which is that every American be guaranteed health care that is affordable, health insurance which is portable from job to job and which they cannot lose. Every major country in the world does that for its citizens. We are the only advanced nation in the world that does not provide guaranteed health care for every one of its citizens.

Universal coverage is central to reform for many reasons.

First, simple justice. Again, every free democratic nation provides its citizens with a right to basic health care, at a cost which he or she can afford. But second, without universal coverage, prices are going to continue to rise sharply and costs are going to continue to be shifted to those who have insurance in order to pay for services which must be provided to those who do not.

Reforms like portability, allowing a worker to take his or her insurance from job to job, and the elimination of those restrictions relative to preexisting conditions, are not workable without universal health care. The closer and the faster we get to universal guaranteed health coverage, the faster we are going to eliminate the shifting of costs, this bizarre situation which we have in America, where half of the people typically who come to our emergency rooms do not have emergency problems. The reason they are going there is because they do not have health insurance.

I have visited emergency rooms across the State of Michigan. I went to the emergency room in Hurley Medical Center, in Flint. They had 52,000 emergency visits last year; 34,000 of them not emergency cases. Think of the waste, the sheer waste of the present system in that hospital—34,000 of the 52,000 visits in that hospital in Flint, MI, are nonemergency visits. And they go to the emergency room, using the most expensive equipment we have, some of the most expensive talent we have, and multiply that by hundreds of hospitals across this country.

Naturally, two different surveys reached different conclusions. GAO says 43 percent of emergency room patients do not have urgent needs. That is a GAO study. That is across the Nation. Why? They do not have insurance. They go to the emergency room because they cannot go to a doctor, to a clinic, because they do not have insurance. So they go to emergency rooms and use those facilities.

According to a more recent National Center for Health Statistics study in March 1994, 55 percent of the 90 million emergency room visits in this country were not urgent. That is the current system. We have to change it. We cannot change that without universal coverage.

I have a lady whom we have been trying to help in my office, who was covered by three different insurance policies. She cannot get any of them to cover her bills because each of them points to the other insurance company as being the principal company responsible. They all admit one of them is going to have to pay, but they all deny coverage and say go somewhere else. And the other company says go somewhere else.

This is a woman who had three policies covering and cannot get them to pay, and this is for a serious illness that she has.

We think the Mitchell bill is thick, and it is. As complicated as it is, she has a box of bills and a box of paper relative to her problem. The paperwork involving her illness makes this look like a single sheet of paper, this Mitchell bill. That is the current system where she is played like a ping-pong ball from company to company, each one acknowledging, "Yeah, she's covered by someone but not us."

That is eliminated under the Mitchell bill. That cannot happen under the Mitchell bill. Those companies have to pay and then argue among themselves who it is who is ultimately responsible, and not force citizens of this country to be inundated, swamped with paper in the mail, which is meaningless paper and the ultimate in waste.

How many folks go to a hospital and then open up the mail weeks later and get a ton of paper that says, "This is not a bill." Most of the new people that we hire in the health field are clerical people, now in America, not providing nursing care, medical care and health care, but typing out forms.

One insurance provider in my home State has 300 different varieties of policies. That is just one provider—300 versions of a health care policy. That is the current system.

Mr. President, let me close with some numbers that relate to my home State of Michigan. We have about 900,000 people in Michigan that do not have health coverage. Over 700,000 of them are working people. About 74,000 people in Michigan are losing their insurance each month. Those are the figures, the unacceptable figures, in my home State of Michigan.

I received a letter the other day from a man named Bill Carr who lives in the western part of the State. It is addressed to me. It is regarding, in his words, a hurting Michigan family.

Dear Senator LEVIN: A year ago, I lost my job. For 45 years I worked and paid my dues. Through a quirk of time at the age of 55, there was no work, no unemployment, no place to live, and no medical insurance. During the next 365 days, my wife and I lived a tenuous life. We lived in fear that one of us would get sick, or worse, hospitalized, or God only knows what. We went to County Services for the Unemployed and the Underemployed. They put us on a rating schedule. In other words, we paid according to our income. My wife did become ill. The county treated her but did not know what was the problem, and she ended up going to a hospital. I explained to the hospital I was unemployed, and asked for treatment for my wife. The hospital refused to even talk to a doctor and turned us away.

Today, we still have no insurance, even though I have been working for 30 days. My wife is still ill, and still has not been treated. We are in fear of cancer, but will not know until 60 more days when our insurance kicks in and I can take her to a hospital.

That is the status quo. It is typical of too many letters that come into every one of our offices. Here is a man who, in his own words, represents a hurting Michigan family; in his own words, a man who paid his dues, who is now 55 years old and has lost his job. He then was reemployed, but now is without insurance and they are afraid that his wife has cancer. But they have to wait 60 more days. Only then will insurance kick in and he can take her to a hospital.

That should not happen in America. We are better than that. We are strong

enough, we are rich enough, we are decent enough so that need never happen in America.

And Harry Truman, back in 1947, asked the Congress to end that kind of shame. He closed one of his messages to the Congress asking for universal health care with the following words:

> The total health program which I have proposed is crucial to our national welfare. The heart of that program is national health insurance. Until it is part of our national fabric, we shall be wasting our most precious national resource and shall be perpetuating unnecessary misery and human suffering. I urge the Congress to give immediate attention to the development and enactment of national health insurance.

So President Truman wrote in 1947. It has been true ever since. We should not delay another year, because that will lead to another decade and to another five decades before we end the shame of this kind of a letter, where a person cannot find out if he or she has cancer because they do not have insurance.

I yield the floor.

ORDER OF PROCEDURE

Mr. MITCHELL. Mr. President, as we all know, the rules of the Senate permit unlimited debate; that is, any Senator may speak as long as he or she wishes at any time. Under that rule, any one Senator, or group of Senators, can prevent the Senate from voting or otherwise taking action on measures.

Last night, I proposed to the distinguished Republican leader that we agree to debate the pending amendment, the Dodd amendment on children's health insurance, last night and today, and that on Monday we take up a second amendment, and that we agree to have votes on those amendments at 5 p.m. on Monday. Senator DOLE indicated that he was not able to agree to that, and we so stated last evening.

It had been my hope that we could reach that agreement today, but Senator DOLE has advised me that Republican Senators are unwilling at this time to do so. Senator DOLE is here and will, of course, speak for himself following my remarks.

Therefore, we are in a situation where debate will continue with no assurance, as of today, as to whether or not votes will be permitted on the pending amendment or any other amendment on Monday or at any other time.

Accordingly, I have concluded that no alternative is available to me other than to insist that there be procedural votes on Monday. While I do not have the ability under our rules to compel a vote on the pending amendment or on any other measure, I do have the authority to compel a vote on a procedural matter, and therefore I have concluded and now announce that at 5 p.m. on Monday, if we are unable to reach an agreement prior to then with respect to votes on the pending amendment or other amendments, there will be at least one and possibly more procedural votes.

My meetings with Senator DOLE, as always, have been amicable, and I retain the hope, as I believe he does, that we will be able to reach some kind of an agreement on Monday to permit votes on one or more amendments. So I do not believe that that possibility has been ruled out, simply that there is no ability to reach that agreement today. Therefore, so that all Senators can have full and fair notice of what will occur on Monday, I felt it necessary to make the decision and announcement that I just have this afternoon so that Senators will be able to plan their schedules for Monday accordingly.

Finally, Mr. President, let me say that in view of the fact that the stated reason for an inability to reach agreement on the votes is that several Senators wished to make opening statements, I want to repeat what I said last night, that we are prepared to remain in session today for as long as any Senator wants to stay and speak. So every Senator will have ample opportunity to do so. And on Monday, we will begin our session devoted to this bill and amendments at 10 a.m. and continue for at least 10 hours on that day and possibly 12 hours, and that it will be necessary thereafter to proceed in a similar fashion, subject always, of course, to adjustment pending discussions between myself and Senator DOLE and agreements to the contrary.

Mr. President, as I said, Senator DOLE is present on the floor, and I want at this time to invite him to make any comments he may wish on my remarks. If I have in any way misstated our discussion, I invite him to correct me and make any further remarks he may wish to make.

The PRESIDING OFFICER. The Republican leader.

Mr. DOLE. Mr. President, I do not have any serious, any real disagreement with the majority leader. We did have the discussion.

I think we have a little different view on this side. We think we should first, before we get into the amendment stage, lay the foundation by a discussion on what is a very important bill and one that we are still waiting on our side for CBO numbers. The House is not even going to take up the health care bill because they do not have CBO numbers.

The distinguished majority leader has numbers on his bill, at least on the first version of his bill. We do not have any numbers on our bill. I understand there will be another bill introduced by the mainstream group. They will be without CBO numbers. Then there is another bill that may come forward by Senators NUNN and DOMENICI and others, pretty much like the Rowland-Bilirakis bill on the House side.

So for a number of reasons, it seemed to us if we are going to get serious about amendments, then we at least ought to know, because we have had people discussing our bill, some people suggesting they had the CBO numbers. Well, if they have them, we wish they would let us have them because we do not have the numbers on our bill.

But having said that, we will, again, as I told the majority leader, have a meeting Monday morning, and I will get back to him after that meeting to see whether or not there is some way we can dispose of the pending amendment, either with a vote or whatever. And, if not, he did indicate to me that there would be at least one, perhaps more than one, procedural vote starting sometime—I guess the majority leader has now set 5 o'clock.

So I would just say that I do not know of anybody on our side who wants to talk 3 or 4 hours. I have said if that is true, I hope I am not here for all that time. In any event, there are a number of people who have not spoken at all. We are trying to keep a list so we do not have repeaters every day. Some may sneak in, but we are trying to keep the list so if you have spoken on the bill, then you have to wait until everybody else has spoken.

Of course, as the majority leader knows, you can speak in morning business or you can speak on some amendments, so you may have the same people speaking several times during the week. But I have conveyed the results of the majority leader's discussion to my colleagues. Senator PACKWOOD is necessarily absent this afternoon. I will visit with him on Monday morning.

Mr. MITCHELL. Mr. President, I thank my colleague. I agree on the importance of getting the CBO scoring on as many bills as are introduced. And the CBO is, of course, heavily burdened with the many respective bills.

I respect the right of any Senator or group of Senators to introduce a bill. And while I know all of the efforts described have been serious efforts so far, I think it is obvious to the minority leader and to all of us that if we adopted a process that we could not proceed so long as some Senator was going to introduce another bill that had to be scored, why, any Senator who did not want ever to do reform could simply indefinitely prolong the process by introducing a succession of bills that would require scoring, and there would be a new mechanism for delay.

I do not believe that to have been the case so far, as I think all of the bills introduced have been serious efforts and they represent Senators' genuine expressions of how they think we should proceed.

But I look forward to the results of the Republican leader's discussion with his colleagues on Monday and hope that we can resume our dialog and perhaps reach an agreement on Monday to

permit a vote on one or more of these amendments.

Mr. DOLE. Could I just add—I think I did—we did make our request on July 25 on Dole-Packwood, and then again we sent a reminder on Tuesday, August 9. We are not faulting CBO. They have a great deal of work to do. But we do think, if we want to offer ours, say, as a substitute to the pending bill, I think other colleagues on the other side of the aisle will say, "What does your bill cost? What do these things cost?" If it is so serious the House cannot bring up theirs with numbers, we are somewhat at a loss to what we do if we reach that point. But maybe we ought to have the numbers soon—we hope.

ORDERS FOR MONDAY, AUGUST 15, 1994

Mr. MITCHELL. Mr. President, I ask unanimous consent that when the Senate completes its business today, it stand in recess until 10 a.m. on Monday, August 15; that following the prayer the Journal of proceedings be deemed approved to date and the time for the two leaders reserved for their use later in the day; that immediately thereafter the Senate resume consideration of S. 2351, the Health Security Act, with the time until 5 p.m. equally divided and controlled between Senators MOYNIHAN and PACKWOOD or their designees; provided further that at 5 p.m. the Senate vote on a motion to instruct the Sergeant at Arms to request the presence of absent Senators.

The PRESIDING OFFICER. Is there objection?

Mr. DOLE. Mr. President, as I understand it, if there is some other disposition, we should get an agreement to vote on the amendment at 5 o'clock, the majority leader might change the order?

Mr. MITCHELL. That is correct. Yes. This will occur only if we cannot reach an agreement. I wanted to give the maximum notice possible to Senators with respect to that schedule.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. MITCHELL. Mr. President, I now ask unanimous consent that it be in order to request the yeas and nays on the motion to instruct.

The PRESIDING OFFICER. Is there an objection?

Without objection, it is so ordered.

Mr. MITCHELL. Mr. President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

Mr. MITCHELL. Mr. President, I thank my colleagues. I thank the Senator from Michigan for his courtesy.

I yield the floor.

The PRESIDING OFFICER. The Republican leader.

Mr. DOLE. Mr. President, has leader time been reserved?

The PRESIDING OFFICER. Leader time is reserved.

Mr. DOLE. Might I use about 2 or 3 minutes of that without upsetting the balance on the health care debate?

The PRESIDING OFFICER. The Senator may use his leader time.

ISSUES BEFORE THE CONGRESS

Mr. DOLE. Mr. President, I think it is pretty clear we have a lot of big issues we are trying to deal with, and one right now is health care. There are other big issues out there, such as crime. One that is coming up is the trade bill—particularly implementing legislation for the Uruguay round agreement.

Mr. President, there are a number of momentous issues before the Congress right now—each of them deserves thorough scrutiny and extensive debate before Congress acts.

I am certain that every office has been like mine. I have had more calls on GATT than I have ever had on NAFTA. For some reason, people say they do not have enough information, or they are just outright opposed to GATT. Maybe it is because they do not understand it.

Calls and letters have been flooding into my office—and I am sure to my colleagues' offices too—on the subject of the GATT. People are uneasy, Mr. President. They are concerned, they are afraid they do not have enough information, or they are just outright opposed.

My own office in Wichita is receiving more calls in opposition to this trade agreement than we received on the North American Free-Trade Agreement. I do not know whether opposition will build to the same national level. But I do know that the administration has done a poor job of explaining this bill, not to mention the underlying trade agreement, to the American people.

It is a big, big agreement. NAFTA, by comparison, is very, very, very small.

Mr. President, I want to make it clear that I favor free trade and opening of foreign markets. I fought hard for the North American Free-Trade Agreement. Overall, I favor the GATT agreement because I believe it will help the American farmer and American manufacturers by providing greater global market access. And it will help the American consumer, by lowering tariffs worldwide and thereby lowering the prices of products.

But, Mr. President, people have a right to know what else is in this agreement. People have a right to know how the World Trade Organization will function, what powers it will have, what authority it will have to tell the United States what to do. People have a right to know how the agreement will be paid for, and how it will benefit them in the long run. I know these are significant concerns to Members on both sides of the aisle here in the Senate.

In addition, people have a right to know how this trade agreement fits into the President's long-term trade strategy. President Clinton wants fast-track authority for future trade agreements.

I do not fault him for that. He wants language in the trade bill referencing all kinds of environmental and labor objectives and linkages of trade policy to environmental policy and labor policy. People want to know whether the President's strategy is to turn over our trade laws to environmental groups to be used as clubs over the heads of less-developed countries. They want to know whether labor unions will decide who we should trade with—based on the level of enlightenment in our trading partners' labor laws.

What disturbs me, Mr. President, is the failure of the administration to allow adequate time for the American people to get answers to these and other valid questions about this trade bill.

We have to ask ourselves, we have to ask ourselves right now: Is there a rush? Do we have to do this this year?

I think everyone on the Finance Committee wants to be cooperative.

What is the rush? There is no rush. Yet we read in this morning's paper about a deal the administration cut yesterday with Members of the House that supposedly will allow this bill to move forward.

Maybe so; maybe not. I have talked to some of the House Members. They are not certain if they have any agreement. But it seems to me that with all the things we have coming up, if we are going to do this, maybe we ought to do it this year; maybe we ought to set the pattern for other countries. But we ought to make certain precisely what we are looking at and what we are dealing with and, I think, also, maybe listen to our constituents.

Again, they want to be heard. They do not maybe understand the fast track or all of these things. What they do not understand, they just do not understand why we are trying to move on something when they think there may be a problem.

So we still have some time. I know the chairman is on the floor. He has worked very hard. We have reported out implementing legislation. But I think what I would say is let us not race to complete a major trade bill before we can calm the doubts of almost everyone.

You are never going to calm the doubts of everyone until we can answer the questions of most people out there. Some are going to be critics forever. But I think for those who have legitimate concerns, they are certainly entitled to legitimate answers.

What is the rush?

There is plenty of time for Congress, and the American people, to take a close look at the results of the Uruguay round. There is no need whatsoever to force this bill through in the closing days of this session, when most Members of Congress are fully engaged in other, momentous issues. This is an important issue. This trade agreement will have a profound impact on our trade relations with every nation on Earth, on our rights as the largest trading nation on Earth and on our ability to resolve trade disputes as they arise with other countries.

I urge my colleagues to listen to their constituents, take the time to carefully consider this important legislation, and give the American people the chance to be heard on this issue. This bill gets fast-track treatment in Congress. That means that once the committees complete their work and the House and Senate work out their differences, the President can submit the bill any time and no amendments are permitted.

So let us take the time to get it right. The committees involved do not need to rush to wrap up their work on the GATT bill this week or next week or even next month. The worst thing that happens if we take time for careful consideration is that everyone, including the people who live outside the beltway, will understand what this trade bill is all about, and may even decide it is a good thing for the country.

For now, Mr. President, let us not race to complete a major trade bill before everyone's doubts are calmed and questions fully answered. We owe it to the American people.

I thank the Chair. I thank my colleague.

Mr. MOYNIHAN addressed the Chair.

The PRESIDING OFFICER. The Senator from New York.

Mr. MOYNIHAN. Mr. President, if I may just join with the distinguished and indefatigable Republican leader in commenting on the reports in the press this morning that an agreement has been tentatively reached between the administration and the Republican Members of the House, and that authorizing legislation has to be worked out in the Committee on Ways and Means.

The Committee on Finance has finished its work, pending a conference with the House Ways and Means Committee. This Uruguay round is a culmination of 60 years of American foreign trade policy that began literally 60 years ago, in 1934, with the Multilateral Trade Agreements Act under President Roosevelt and Cordell Hull.

The Uruguay round was commenced by President Reagan, and continued by President Bush, and finalized by President Clinton. It is an enormous undertaking. I would hope I could go out to Wichita and tell some of those people that it is the best opportunity for American agriculture that we have ever negotiated—an end to export subsidies.

We are the most competitive agriculture in the world, drowned out by subsidies, particularly in the European Union. We bring activities such as counter under the free trade rules, and 117 nations are brought into the system—well, half of them are—but truly into the system.

It is an enormous opportunity. A curious left and right alliance has risen up against it. I think we can answer their questions. We will certainly have an opportunity to do so in conference with the House. But when the President sends us back the bill, we will have an opportunity on this floor to set it forth.

We think that in the end we will be better off. There will be more jobs, more wealth, and more revenue for the Federal Government. That was the basis on which a substantially unanimous Finance Committee acted. And, of course, the Republican leader was one of the leaders of that action. I acknowledge his leadership and thank him. I say, Mr. President, the news this morning was good news.

I yield the floor.

Mr. MACK addressed the Chair.

The PRESIDING OFFICER. The Senator from Florida [Mr. MACK], is recognized.

Mr. MACK. Mr. President, I yield myself whatever time I may consume.

The PRESIDING OFFICER. The Senator is recognized.

Mr. MACK. Mr. President, this debate has been a difficult personal voyage for me. Over the years, my family, like so many others has been in and out of hospitals and doctors offices, as patients, visitors family members, and friends. I have experienced the spectrum of emotions—the grief and depression that set in after my brother Michael died of cancer; the highs and the lows—the roller coaster ride of his 12-year fight against melanoma; the euphoria that followed the delivery of my daughter's third son after her successful fight against cervical cancer; the pride I felt for my mother in her stoic and determined battle she won against breast cancer; the fear of loss, loneliness, and permanent separation that flashed through my mind when my wife, Priscilla, told me she had discovered a lump during a self breast exam; the terror that rocked me when I was told that I was diagnosed with melanoma, the same vicious cancer that had killed my brother 15 years ago.

In a matter of seconds, I relived the trauma, the pain and suffering my family endured during Michael's struggle. Michael's life was extended 12 years, and four of the five of us are alive today because of receiving services from the best health care system in the world.

I will fight the destruction of our system with everything I have because of my own very strong beliefs and because the people of America share these same ideals.

Let me take a few moments to talk about our present system. Our system provides us with the freedom to choose providers and benefits. We have the highest quality of care and lead the world in innovation. These are the defining features which make our system second to none. The quality of our system attracts patients from all over the world, whose own health care system has failed them.

We provide employers with positive incentives to provide health care for their employees. The decision is the employer's as to whether or not they are financially able to do so. We encourage Americans to take advantage of preventive services, such as periodic screening for diseases and immunization for our children. We advocate routine exercise programs and eating a balanced diet. We lead the world in research and development of pharmaceutical drugs and medical devices—products which have saved millions of lives and which have improved the quality of life for so many Americans—individuals with so much life still to live.

Is it a perfect system? No, it is not. There are indeed many reforms needed which would significantly improve opportunities for health care coverage.

While Mrs. Clinton says her opponents lack compassion, this could not be further from the truth. I want health care for all Americans. I just do not believe that big government is the answer. Later I will go over the legislative changes that are needed and should be passed.

Accomplishing specific reforms ought to be straightforward. In fact, the American people should know that these reforms could have been passed already. Two years ago, I served on a bipartisan health care task force to pave the way for passage of reforms. We all agreed it would enhance the opportunity for health care coverage for more Americans. These included: Insurance market reforms and small group purchasing organizations, as advocated in the Bentsen bill; community health centers; deductibility of health insurance premiums for the self employed and individuals; State experimentation; medical liability reform; reduced administrative costs, and primary and preventative care incentives—all would significantly improve the health care of our citizens.

Two years ago, Republicans were prepared to pass these needed reforms—incentives which could already be providing greater access to our health care system at affordable rates. So why did it not pass? Because Democrats informed us that it was all or nothing; either create a Government-controlled

system or nothing. During the past 2 years, more people have lost their insurance because the Democrats said, "all or nothing." During the past 2 years, people have been denied coverage because of preexisting conditions because Democrats said "all or nothing." During the past 2 years, the self-employed have been financially disadvantaged because the Democrats said "all or nothing." During the past 2 years, administrative burdens have increased because the Democrats said "all or nothing."

History has a nasty habit of repeating itself. Guess what, folks. Two years later, we are confronted with that same choice: A Government-controlled, Government-dictated health care system with less quality, less choice, and less freedom on the one hand, or a market-driven health care system with high quality and more choice and more freedom on the other. The decision for me is simple—the American people do not want to be told where they must get care, from whom they must receive it, and the type of care they are entitled to, according to an all-powerful Government board.

Much of this debate has focused on the concept of universal coverage. People ask, "Are you for universal coverage or are you against universal coverage?" It has become clear that there is no single definition for the term "universal coverage." Does it mean 100 percent coverage? Does it mean 95 percent coverage? Does it mean 91 percent coverage or, perhaps, something in between? If universal coverage means that everyone is mandated to participate, what does that say about our commitment to individual freedom?

President Clinton continually stresses security as his No. 1 goal, along with universality. The Clinton-Mitchell plan would force everyone to participate in these plans—like it or not. I have friends on the other side of the aisle who want to push through a health care bill regardless of the views of the American people. I believe that a social system that is built on the idea of security and guaranteed benefits, separates consequences from action, separates freedom from responsibility, and will eventually reduce, restrict, limit, and could finally lead to the destruction of our liberties.

Recently, Thomas Sowell wrote an article entitled "Selling Freedom for Rhetoric." I would like to share some of his thoughts with you:

> Make no mistake about it. Your freedom and independence—what you celebrate on the Fourth of July—are precisely what must be taken away, in order that we may all become dependent on the largess of Washington and become the guinea pigs of the social experimenters * * * We are talking about the government telling you and your doctors what you can and cannot do, politicians and bureaucrats micromanaging medicine * * * Government is not about 'asking.'* * * It is about telling * * *

What about our freedoms as Americans? Thomas Sowell could not possibly have been more clear when he said: "No freedom can be more personal than the freedom to decide for yourself what should be done to preserve your health and your life."

Let us examine the destruction of our freedom envisioned in the Clinton-Mitchell health bill.

First, the issue of choice. Polls have consistently shown the American people want to choose the type of care they get and from whom they can get that care. A Government bureaucrat should not be making that decision for them.

I want to go back to my comments earlier about my brother's death due to melanoma in 1979. While that was 15 years ago, it seems as vivid today as it was then. I am going to talk about that in using this chart which shows the bureaucracy in the Clinton-Mitchell bill.

First, I want to say there are probably some who think this is just a chart that someone has made up, a figment of someone's imagination, but I assure you this chart, put together by Senator SPECTER was developed by going through the 1,400-and-some page bill. Senator COATS and Senator GREGG put this primer together which details the 50-plus new bureaucracies. Every one of these new programs, every one of these new bureaucracies is identified as to the section of the bill from which it comes.

I will just say to those who are listening, can you imagine what it must be like or could be like if you were sitting with me in a hospital room in Atlanta, GA, in 1979, when your brother, a brother you loved so dearly, was suffering so much. There you were working with his doctor trying to figure out what was the next best option, what procedure might be used, what medication might be available to reduce his pain, what new technology might be available that could possibly extend his life or improve the quality of his life. Right in the middle of that discussion, right between me and Michael's doctor is this massive new Government bureaucracy—a wall, in essence, that has been established that acts as a barrier, a group of bureaucrats, who I will say are well-intended, who would say to me or to the doctor that that medical procedure is not available any longer or that new technology has not been approved by the Board.

Now, I must tell you I do not believe that this is the kind of health care that the overwhelming majority of Americans want for this country.

(Mr. ROCKEFELLER assumed the chair.)

Mr. MACK. Mr. President, the Clinton-Mitchell bill provides no real choice of health care benefit plans at all. All plans will be cloned with the same set of standard benefits determined by the National Health Benefits Board. Oh, sure, you might be able to decide whether your health care benefits will be handled by an HMO or preferred-provider arrangement or a fee-for-service plan, but all benefits will be the same—fixed by Government. But, despite the rhetoric from my colleagues, you will not have the freedom to choose the physicians or treatment that you need. The Board will be given the power to determine whether health care is medically necessary and appropriate, not the physicians.

Representing a State of more than 13 million people, you can imagine the correspondence and phone calls that I have received on this issue. The other day I received a letter indicative of many others I have received. The writer stated:

> I do not delegate the right to take care of my health care and medical needs to the U.S. Government.

What does the national Board know about what is appropriate and medically necessary for families in Ruskin, FL, or a grandfather in Little Rock, AR? These decisions must be made by a patient in consultation with his or her medical provider—case closed.

What about this take-it-or-leave-it standard benefits package? The American people know that one size does not fit all. I want no part of a plan that forces Americans to change insurance plans they are satisfied with because the Government knows better than the American people what type of benefits they need.

Frankly, this reminds me of the catastrophic coverage debate of 1988 and 1989 when Medicare beneficiaries were being forced to give up the supplemental coverage they already have because the Government believed a one-size-fits-all package was better. Before the ink was dry, we had to repeal it. Americans rebelled then and, Mr. President, they are rebelling today.

One of the bills I sponsored is the Consumer Choice Health Security Act. This legislation is modeled after the Federal Employees Health Benefit Plan [FEHBP], the plan Congress and over 3 million Federal employees belong to around the country. It offers members the choice of more than 300 health insurance plans with a vast variety of benefit options.

The Dole bill encourages Americans to join FEHBP and choose the health care plan with benefit options that are best for them and their families. Unfortunately, the Clinton-Mitchell plan takes a good program full of choice and obliterates it.

Choice will be severely affected by the premium caps in the Clinton-Mitchell bill as well as the 18 new taxes proposed in the bill. As Government squeezes down on resources, we will be forced to give up choices of benefits, of plans, of providers—choices which we have always believed would be available to us in our health care delivery system.

Mr. President, that brings to mind a conference on health care that I held in Jacksonville, FL, several years ago. We had two physicians from Canada who came to talk about the Canadian system. They told us that there was overwhelming support in Canada for their system. But, one of the things that they said that I think is very, very important and should never be forgotten is, that you cannot take the ideas and plans that have created a health care system for society, for some other nation, and superimpose them on yours. They said to us: "You've got to develop a plan, you've got to develop a health care system based on the values of your society."

And that is why this debate is so important, and it is so important for us to listen to what the American people, in fact, are telling us.

Next, let us look at the issue of quality within the Clinton-Mitchell bill. The bill states that the National Health Benefits Board shall be authorized to establish guidelines as to what is medically appropriate. Furthermore, the bill mandates that a health plan has developed a treatment guideline or utilization protocol, then it must provide this in a written statement at least 60 days ahead of time to each affected provider and the Government entity which certifies the plan.

Can you imagine how this process could interfere in the practice of medicine and patient care? Let me give you an example. A person goes to a doctor to have a mole removed from his neck. The doctor discovers that more tissue needs to be removed because what first looked like a harmless mole may possibly be a melanoma. So the guideline for treatment is different. What should the doctor do or have done differently?

The doctor asks a colleague for a second opinion who suggests a different approach because of the appearance of the surrounding tissue. What may be very good medicine may not fit the protocol for the already approved procedure. Did they follow the guideline? Did they modify the guideline? Did the outcome fit with the expectation for the treatment? Is this the thought process we want physicians to go through apart from what they think is best for their patients?

Many of us, who have experienced our children coming down with the croup, can remember the anxious time we spent at night listening to that raspy and painful sounding cough while trying to decide whether to go to the emergency room. The August 4 edition of the New England Journal of Medicine describes how a new drug inhaled through a nebulizer allowed children with the croup to be discharged from the emergency room significantly earlier and needed less medication afterward than the children who had received a placebo.

I assure you, if my grandson had the croup tonight, I would want him to have the option to receive this treatment. How are pediatricians in health plans going to do this if a Government-preapproved guideline is not in place? After all, this is not a tried and true treatment but something new and innovative.

The next area I want to address is price controls. Price controls were originally advocated by President Clinton and are now being proposed by Senator MITCHELL in the form of taxes on insurance plans and a target for premiums which will threaten the quality of care.

Those who favor price controls, in whatever form, often do so without addressing the effects of those controls. For every action, there is an equal and opposite reaction. If we place a cap on how much is spent, there will have to be some reaction to it. The number of medical procedures will decline and rationing of services will occur. Specialty services will be terminated and consolidated with fewer services available to most people. Research and education will be slashed as a means to meet the cap. Development of new drugs will come to a standstill. The quality of our health care will be dramatically affected.

Soon after the Clinton health care bill was introduced, a letter signed by 562 leading economists was sent to the President. These economists wrote that the administration's government-run health care system "will produce shortages, black markets, and reduced quality."

The economists concluded that,

In countries that have imposed these types of regulations, patients face delays of months and years for surgery, government bureaucrats decide treatment options instead of doctors or patients, and innovations in medical techniques, and pharmaceuticals are drastically reduced.

Finally, the economists concluded,

Caps, fee schedules and other government regulations may appear to reduce medical spending, but such gains are illusory. We will instead end up with lower-quality medical care, reduced medical innovation, and expensive new bureaucracies to monitor compliance.

Unfortunately for all Americans, this same letter could have been written about the Clinton-Mitchell plan.

I would like to share with your some examples from other countries that have imposed price controls.

Last Christmas, in an effort to meet budgets, some 100 hospitals in Ontario—Canada's most populous province—shutdown wards and surgeries for 3 weeks with doctors going unpaid and nonemergency patients untreated.

On June 8, 1994, the Times in London featured a story entitled, "Patient with Indigestion gets April 1996 appointment."

Again, "Patient with Indigestion gets April 1996 appointment. Consultant serves 280,000 people, twice recommended level."

The patient, David Fullbrook, received a letter from the National Health Service Trust, which stated the following, "No guarantee can be given that you will be seen precisely at the time stated or by the consultant named."

The article discusses the doctor's frustrations with the fact that he is the only specialist serving a large area. A spokesperson for the British health care system acknowledges that these waiting periods need to be urgently corrected and a review of medical manpower is underway. Can you imagine what this gentleman must be feeling? Two years to see a specialist, but do not worry, he is told, his government is going to study how to speed things up for him.

A woman in Florida told me her father, who gets his care under Britain's Government-controlled system, had to wait so long for a cataract operation that by the time the surgery was scheduled, his eyes were inoperable. My father had cataract surgery when he needed it and I want to make certain our citizens have quality health care when they need it.

The Clinton-Mitchell bill wants to control the number of specialists in our country similar to the British system. The Clinton-Mitchell bill, in fact, creates a National Commission on Graduate Medical Education tasked with controlling the number of specialists in our country. This bureaucracy would require a ratio of 55 percent generalists to 45 percent specialists. So, if your life-long dream has been to be an ophthalmologist or to discover a cure for breast cancer, you might want to rethink your dreams. The Government may have other plans for you. This is an arbitrary ratio which will not only limit care but also reduce research. They have forgotten that specialists are the pioneers of medical innovation. Do we really want to set bureaucratic limits on the talent we allow into the system? I think not. Such limitations will forever change the quality of our care, and severely restrict our choice of providers and services.

Another victim of the Clinton-Mitchell bill is research. We are close to amazing breakthroughs in medicine—maybe the kind of discoveries that could have saved my brother Michael's life. The American spirit of innovation can only flourish with less government, not more government.

Innovations in American laboratories during the first half of this century have practically eradicated such killers as measles, tuberculosis, polio, and whooping cough. We are in danger of destroying that spirit.

The mere threat of price controls by the administration on the pharmaceutical industry has been decreased research and development at drug companies. From December 1992 to March 1994, the total decline of the industry

stock value was approximately $50.5 billion, a decrease of 25 percent. This is capital that would be used to find cures that could affect your family members and loved ones.

Mr. President, this is a point I do want to focus on for just a minute, because I think its consequences could be extremely serious.

Before I make some other relevant points, I have read some rather interesting books on the subject of DNA, gene therapy, immunotherapy, and the work that is being done to identify genes related to specific diseases.

I refer to two books, "The Secret of Life," and the other, "The Transformed Cell," a book written by Dr. Steven Rosenberg, a physician-scientist out at the National Cancer Institute.

This book is of particular interest to me, since Dr. Rosenberg focuses in on the issue of melanoma. About the time Michael was diagnosed with the disease, frankly, there was no treatment. But today, at the National Cancer Institute, we are seeing remarkable things happen. We are seeing people who have, in fact, been cured of melanoma because of work done by Dr. Steven Rosenberg, in being able to turn on the immune system. Ironically, for some reason, the immune system sees cancer cells and believes that those cells are natural cells to the body and the immune system does not attack it.

What Dr. Rosenberg and others have been working on is how do you use a protein to identify that cancer cell which sends a signal to the immune system to turn on and attack it and kill the disease. And they are making real progress.

But, again, Mr. President, my concern is that under a Government-controlled system in which there will be some cap or some effort to control how much we spend on health care, what is going to happen, which is natural through the political process, is that we are going to take scarce resources and we are going to identify and target those to what most people would think should be done. And that is the day-to-day concerns of people in the hospitals, clinics, and doctors' offices around the country. In the end, money that will be available for research will dry up.

The loss in value of American drug companies is one cause among several to have had a profound effect on the ability of American scientists to bring the fruits of their genius and innovation into production for the benefit of patients. This slowdown has occurred for five major reasons. First, the loss of capitalization of American health care product manufacturers, that I just mentioned, affects their ability to borrow and invest in the development of new products. Second, the decline in research funding reduces the fuel to drive the NIH intramural and extramural intellectual scientific engine which is behind the phenomenal medical advances of the last 30 years.

Third, the costly maze of regulation required by the FDA inhibits bringing products to market. Fourth, the impact of the fear of liability by device manufacturers and their suppliers. This is no longer just a question of whether a device worked properly but includes the reluctance of suppliers to sell materials to manufacturers and then have to defend their product later on in court. And, fifth, the refusal by third party payers; insurance companies, HMO's, Medicare; to pay for new or improved technology.

For years university researchers created ideas that were supported by the NIH. Investors then funded these ideas so that they could be further refined into a product which then had to be tested, approved, and brought to market. All of this took place in the United States. Now, we see American companies first bringing products to market overseas. Europeans, South Americans, and others are quickly able to use American products that cannot make it through our regulatory maze. One leading midwestern manufacturer of therapeutic medical devices has not introduced a major new project first to the U.S. market in 10 years. There is a shift in the international center of gravity for medical device innovation out of the United States. Products are now introduced, then manufactured and ultimately developed in research and development facilities overseas.

I ask unanimous consent to print in the RECORD a statement on this problem by Dr. Pierre M. Galletti, professor of medical sciences at Brown University and current president of the American Institute for Medical and Biological Engineering.

There being no objection, the letter was ordered to be printed in the RECORD, as follows:

BROWN UNIVERSITY,
Providence, RI, August 12, 1994.

Senator CONNIE MACK,
Hart Senate Office Building,
Washington, DC.

DEAR SENATOR MACK: One neglected issue in the debate on health care reform is the impact of proposed legislation on innovation in medical technology and the resulting competitiveness of the U.S. medical product industry. I speak to these issues as an investigator in artificial organs and implants with substantial experience in technology transfer from the research laboratory to industry, and as chairman or member of Scientific Advisory Boards to several product manufacturers here and abroad.

There is no denying that the mere fact of debating health care reform with the dominant accent on cost containment has had a profound negative influence on technological innovation in medicine. The market valuation of U.S. pharmaceutical companies has been substantially diminished, and with it the capacity to invest in new product development. To maintain competitiveness, a counter-strategy has evolved whereby drug manufacturers seek to protect their market share by alliances with somewhat monopolistic distribution networks or investment in less expensive generic products.

No such strategy exists for medical device manufacturers. This branch of the U.S. industry consists primarily of medium size and small companies. They do not have the cash reserves needed for a major strategic shift and, because of their division in multiple market segments, cannot easily ally themselves with provider or consumer groups. As a result, the stocks of biotech companies have plunged by more than fifty percent compared to a year ago. The willingness of manufacturers to proceed with new products has been discouraged. The availability of private venture capital has been severely curtailed. Clinical product evaluation and, increasingly, production are shifting from the U.S. to Europe, where the business and regulatory climate are felt to be less stifling.

The net effect, after perhaps a short period of savings on health care costs because of unavailability of new products, will be a long term increase in health care costs. Think simply where we would be if there had not been products for one-day hospitalization for gall bladder surgery with minimally invasive technology; no intraocular implants for the treatment of cataracts; and no cardiac pacemakers for controlling chaotic heart action. None of these advances would have been possible without an investment of government funds in research, and a much larger investment of private capital to turn inventions into products. Most researchers are in this game for the satisfaction of being identified with medical advances. Most investors are in the game for turning out a profit. This synergy has worked to the advantage of the American economy: the U.S. medical product industry, particularly in the artificial organ and implantable device area, dominates the world market and has grown to a volume of several billion dollars, employing tens of thousands of people.

If we drive early stage research abroad, if we continue to let our regulatory apparatus delay authorizations to proceed with product evaluation with senseless queries, if we make capital investment in new medical products less rewarding, then we will effectively kill the U.S. leadership in bringing new medical products to the market. Exports will eventually become imports. An apparent short term saving will become a new health care burden, because the American people simply will not do without products which have demonstrably increased their quality of life and, in many cases, their actual life expectancy.

Cordially,

PIERRE M. GALLETTI, M.D., PH.D.
Vice President Emeritus, Biology & Medicine.

Mr. MACK. I also want to read just a bit from that. He says:

There is no denying that the mere fact of debating health care reform with the dominant accent on cost containment has had a profound negative influence on technological innovation in medicine. The market valuation of U.S. pharmaceutical companies has been substantially diminished, and with it the capacity to invest in new product development.

He goes on:

The net effect, after perhaps a short period of savings on health care costs because of unavailability of new products, will be a long term increase in health costs.

As we ratchet down on health care dollars to pay for an explosion in Government bureaucracy, we will ration technology innovation and, in the end,

invest less resources to improve quality of life.

Researchers at the National Center for Human Genome Research and grant recipients from the Center are closing in on identifying the breast cancer gene. Once the gene is discovered, we will actually be able to let women know at an early age if they are predisposed to developing breast cancer due to genetic makeup.

The following are just a few of the many promising drugs in the final phase of FDA approval: Ropinerole, which shows great promise for people with Parkinson's disease; Arvin, which will be used for stroke, and affliction which kills more than 17,000 people a year; and Casodex for prostate cancer, which kills 38,000 men a year. The development of these and other future wonder drugs will be placed at risk by the Clinton-Mitchell Government-controlled medicine.

Let us take a look at innovation in delivery of services under the Clinton-Mitchell bill, specifically the ability to self-insure. The bill makes it illegal to self-insure if you have under 500 employees.

In my travels around the State, I have spoken with many employers who have instituted innovative ideas to ensure a healthy workforce—a company doctor, an onsite health clinic, incentives for healthy lifestyles such as an in-house jogging track and exercise room.

Many employers in my State who have self-insured plans have done a tremendous job in holding down health care costs for their employees. A citrus packer in Ocoee with 13 employees has been self-funded for 3 years and has saved $75,000 during that time. A law firm in Tampa, FL, with 26 employees has saved more than $75,000 over 4 years. How? By being innovative, encouraging their employees to seek preventive care, and by promoting individual responsibility in health care.

Under the Clinton-Mitchell bill these creative and cost-saving ideas as part of a self-insured plan would be outlawed for employers with less than 500. Why? Because Clinton-Mitchell rests on the premise that the Federal Government can make better choices than you can.

Before abdicating our rights to the Government, we should examine the Government's track record in estimating the costs and complexity of Government programs. It is not good.

Last year, Joseph Califano, Secretary of HHS under President Jimmy Carter wrote about the effects of the unintended consequences of Government actions:

> As the President, Hillary Rodham Clinton and Congress set out to reinvent health care in America, they are wise to consult widely, since we got into much of the current mess by acting on the best of intentions without foreseeing the worst of unintended consequences.

Medicare was estimated to cost $9 billion in 1990 when it was originally estimated in 1965. Instead, the actual cost in 1990 was off by 1,178 percent, nearly 12 times higher—the unintended consequenses of Government action.

The Mitchell bill contains at least 50 new bureaucracies designated to simplify the health care system—the National Health Care Cost and Coverage Commission; the National Health Benefits Board; the Mandatory State-based Alternative Dispute Resolution, and the list goes on and on—what will be the unintended consequences of these Government actions? The administration and my Democratic colleagues will try and tell you that the Republicans are using scare tactics.

Earlier I went through how we came up with this information. It is clearly and well defined. It comes right from the Clinton-Mitchell bill that has been introduced.

Finally, let us take a look at the disastrous effects of the Clinton-Mitchell bill when it comes to the employer mandate. Under the original Clinton bill, estimates on job loss ranged from 600,000 to 3.8 million. The new Clinton-Mitchell bill would also clearly result in substantial job loss.

A trigger for an employer mandate in the future is no different than an employer mandate today. A mandate is a disguised tax, making employers legally responsible for financing a huge Government entitlement program. CBO, in essence, acknowledged that employer mandates are taxes.

In the final analysis, a tax trigger as advocated by the Clinton-Mitchell bill will result in job loss, wage reductions, and major administrative paperwork nightmares for small business owners and their employees.

Small business owners are wise to Washington. They know what an employer mandate means—a disguised way to pay for a new social experiment. A recent NFIB survey recognized this truth when over two-thirds of the 600,000 members polled opposed Congress establishing a mandatory national health insurance program.

Since beginning this health care debate over 3 years ago, I have been actively pursuing ways to improve the best health care system in the world.

I have been an active member of the Senate Republican Health Care Task Force, and I worked with my colleagues, Senators NICKLES and HATCH and the Heritage Foundation in developing the Consumer Choice Health Security Act. Modeled after the Federal Employees Health Benefit Plan, the bill provides individuals and families the opportunity to purchase the health care plan that best addresses their individual needs. It empowers individuals with choice and individual responsibility.

Because of my strong interest in prevention and specifically, the issue of cancer prevention, I introduced legislation to provide refundable tax credits for all individuals to avail themselves of cancer screening procedures. The American Cancer Society says this one proposal alone could save up to 100,000 lives per year.

As a member of the Appropriations Committee, I have been a vocal advocate for increased funding for research and for the CDC breast and cervical cancer program for low-income women, a successful program with proven results.

We are on the verge of breakthroughs in many drugs that might one day eradicate cancer, Alzheimer's, and heart disease and cystic fibrosis. But when resources are squeezed to fund a $1 trillion explosion in Government bureaucracy, the prevention of those diseases could be put off to another generation.

I worked with the minority leader and Senator PACKWOOD to develop the Dole/Packwood bill. Forty Members have endorsed this legislation. The legislation recognizes the value of a free market approach and imposes no costly employer mandates that would cause job loss.

The Dole-Packwood bill does not impose a one-size-fit-all standard benefit package that limits the free choice of benefits and outlaws existing health insurance plans.

The Dole-Packwood bill does not create a national health board to oversee a government-run health care system;

Does not prohibit small firms from self-insuring and being innovative in delivery of health care services;

Provides all Americans with access to health insurance that is guaranteed to be renewable, portable, and available regardless of any pre-existing conditions;

Preserves unlimited choice of health care plans that are tailored to your needs;

Phases in tax equity for the self-employed and for individuals who do not have employer-sponsored coverage;

It creates medical savings accounts which can be used to pay medical bills or to meet long-term care expenses. The best cost control known to man is a system which allows individuals to make their own choices with their own money on health care;

Allows self-employed and small businesses, 2 to 50 workers, to enroll in the Federal Employees Health Benefit Plan [FEHBP], giving them the same choices among benefit packages that Members of Congress enjoy;

Provides premium subsidies for low-income people for the purchase of a health care plan;

Reforms medical malpractice laws, including capping awards for non-economic damages and sliding scale limits on attorney fees;

Allows for the development of truly voluntary purchasing pools.

In conclusion, I once again find myself thinking about the response I gave to the President's health care address to the Nation in September 1993.

The message I send my colleagues today is the same message I delivered almost 1 year ago: The American people don't want more bureaucracy, more mandates, and more Government control over their health care choices.

The Clinton-Mitchell proposal, which comes with a price tag of at least $1 trillion, creates a Government-controlled, Government-dictated health care system that will hinder quality, choice, and freedom. It imposes at least 17 new taxes, including a surtax of 1.75 percent on every health insurance policy, enacts price controls, requires employer mandates, and creates at least 50 new bureaucracies. In short, it's a prescription for disaster.

Two recent letters from my constituents express the concerns of many Floridians:

> Please do not reduce the quality and availability of health care by voting for the Federal Government to "improve" it by using price controls and redtape. The past "accomplishments" of the Government * * * have resulted in the tremendous cost overruns and recent and constant tax increases * * * I strongly feel that the private sector through market competition can reduce health care costs. Please, vote "no" to any proposed Government control of health care.

The second letter reads, and again I quote:

> I am very concerned about the Health care bills before you. The Mitchell bill I'm afraid will be used as a vehicle to get in Conference where Clinton-Gephardt can be inserted under another name and avoid Debate. * * * The best bill will be * * * the * * * simplest with the least Government involved and the most Free Enterprise as has served to make the Country Strong and Rich.

Mr. President, I want to see that other families, just like mine, have health care. While my Democratic colleagues may have the right motives for reforming our health care system, their method will destroy the best health care system in the world.

My vote, on behalf of my constituents, will be a resounding "no" on the Clinton-Mitchell bill. I will work hard with my colleagues to pass the reforms the American people want and I will not impose upon them a solution they do not want.

A Government controlled system? Never. I will never cast away our freedom for the sake of constructing a social experiment on a foundation of quicksand—the Federal bureaucracy. It is a formula proven time and time again to fail. We must look for solid ground to build any such reforms * * * that ground has always been free markets and free choice. They have served as the foundation for every great stride made by this country in the last 200 years. I will not abandon them nor will the American people abandon them either now or later.

I yield the floor.

Mr. PRYOR addressed the Chair.

The PRESIDING OFFICER. The Senator from Arkansas.

Mr. PRYOR. Mr. President, if I might inquire of the Chair, how much time is left on this side?

The PRESIDING OFFICER. Just about 28 minutes.

Mr. PRYOR. I thank the Chair.

Mr. President, I first want to congratulate my colleague from Florida for his very timely remarks. I also want to congratulate my colleague, Senator BENNETT, for his remarks earlier today. I thought it was a very, very constructive dialog, a very constructive part of this debate on this late Saturday afternoon in the U.S. Senate. I am glad that this debate is occurring, and I am glad also, Mr. President, that I have the opportunity, to correct some of the misimpressions—I know not intentionally made—by my very good friend and colleague from Florida, Senator MACK.

First, there is something I agree with. I agree with my colleague from Florida that we have the highest quality of medical care of any country in the world. I agree 100 percent. I agree 100 percent with my colleague from Florida that we have the highest quality system of medical care for those who have insurance, for those who are wealthy, for those who can afford it, for those who have not had their insurance canceled, for those who have not lost their jobs, and for those who have not been transferred to another State or to another company where they have lost their insurance.

We have a very high quality of health care. And I would like to further state that for those who are in the system, the system is good.

For those who are outside the system, the system is very, very bad. It is so bad, Mr. President, that we have a crisis, and unless we do something, we are going to see the great majority of American families in the next decade, one, not have insurance coverage and, two, not be able to participate in what our colleague from Florida refers to as the best system of health care in the world.

There is another misimpression that my colleague and others of his friends on his side of the aisle have been leaving for the last several days and weeks, and that is that the so-called Mitchell plan is a Government takeover.

It is just the opposite of a Government takeover. The so-called Mitchell plan is a plan to free up the individual to make their own decisions about health care. It is not a Government takeover, and to imply, to state that 17 new taxes—17 new taxes—are going to be imposed under the Mitchell plan is totally, absolutely in error.

Second, to imply that 50 new bureaucracies—50 new bureaucracies—are going to be created under the Mitchell plan? Mr. President, it is not true.

Earlier in the day I was looking at the chart of my friend from Florida. In fact, I went over to examine that chart. I have seen it on TV; I have seen it on the floor all week. So I took the time to go and look at it.

I looked down in the lower left-hand portion or quadrant, of that particular chart about how bad this Mitchell plan proposal is going to be, how many bureaucracies it is going to create. What I saw in the chart that we have seen displayed most of today on the Senate floor is basically part of the system that we have now, that we are trying to get rid of, that we are trying to replace with a new system that is going to be affordable and accessible to every American citizen. Most of that chart, Mr. President, was a chart and I repeat, of the system that we have now.

It is for this reason that we are using an example from the State of Iowa, a small town in the State of Iowa, Clive, IA. We have a chart of a Dr. Gleason's office before Senator Mitchell's plan. Here it is. Here is what happens in this small doctor's office in this small town in Iowa: The literally hundreds of forms and steps that must take place when a patient of Dr. Gleason receives service.

What do we have first? First, we have 1,500 insurance companies in America. The distinguished occupant of the chair knows all of this, probably better than any Member of this body. He has passionately—passionately—pursued this issue and tried to make those necessary changes that make this system not only the best, but keep it the best and make it accessible and affordable to every American.

Look, Mr. President, here we have Medicare, Medicaid. Here are the Blue Cross/Blue Shield programs right here. Here are all the different color codes that show—each different color code is a new form that must be filled out before Mary Jones has her examination or has her finger bandaged, or what have you. Then we have all of the other insurance companies. We could not put all the rest of them on here because there would be over 1,400 of them and they would encircle this entire Senate Chamber. For every one of those insurance companies, there is a different form to fill out.

Under the Mitchell plan, you are not getting more government, you are getting less government. You are not getting less service, you are getting more service. You are not getting a lower quality of health care, you are getting a higher quality of health care.

What you are ultimately getting, though, Mr. President, is efficiency in that system and you are getting simplicity in that system. Because after Senator Mitchell's plan is enacted—if those on the other side will let us enact it—we will see a much simpler plan with basically only three different forms that have to be filled out when

Mary Jones visits the office of Dr. Gleason in Clive, IA.

We think this is remarkable progress, Mr. President. We think it is progress because we think the Mitchell plan is very far superior to that plan offered by Senator Dole and Senator MACK and his colleagues on the other side.

Just one example. Because we think it is better, we will give you one reason we think it is better, among others.

The Senator from Florida represents a State with the highest percentage of elderly population. By the way, Arkansas is second or third in line. I am not sure we are second to Florida, but Florida is first. Florida has more elderly people than any other State percentagewise, yet, mysteriously, the proposal by Senator DOLE and Senator MACK does not include prescription drug benefits for seniors. It does not exist. It is not in the Dole plan. It is nonexistent. It is not even mentioned.

Whereas, in the Mitchell plan, we do begin for Medicare recipients a prescription drug plan that we think is a very, very good start. And we are proud of it. We are proud that we have a prescription drug proposal. We are proud of the fact that the elderly and the seniors and those on Medicare are no longer going to have to reach in their pockets and pay the highest conceivable prices for their prescription drugs.

We can do better as a country. We will do better as a country if we adopt the Mitchell plan for prescription drugs. I think this afternoon's debate has been a good debate because we are beginning to compare, really compare, without all the rhetoric, the Mitchell plan to the Dole plan. Another thing we like better about our plan is we have a proposal, as the Presiding Officer knows, because he was one of the instrumental forces in putting it into the Finance Committee bill, merged into the Mitchell bill, is something that we call long-term care. It is a beginning.

The distinguished occupant of the chair, Senator ROCKEFELLER, has worked for years and years to tell our country of the need for long-term care and to keep people as long as possible out of nursing homes.

Well, Mr. President, if we do nothing—and we have the opportunity here to do nothing, which would be the wrong opportunity to take, I might add, Mr. President, but if we do nothing and if we fail to seize upon this opportunity to do something, a once-in-a-lifetime opportunity to do something about a health care system that is unavailable to 37 million people, that is unaffordable to millions and millions of people, a system that is losing hundreds and hundreds of thousands of insured each year, if we fail that opportunity, I think we have failed in our obligation to the American people as Members of the Senate.

Look at this. We have more than 1,500 health insurance companies in this country, and today we see that we have to fill out 15 more forms for one patient's hospital stay. The lack of standardization of these forms is resulting in higher and higher administrative costs. The number of health administrators, for example, has increased by 300 percent during the past decade. The number of physicians has increased by only 18 percent.

The private insurance carriers in this country employ more than 2.4 million people, almost 2½ million. This is almost as many people as are employed in all of the legislative, judicial, and nondefense executive agencies of the American Federal Government, including all of the postal workers.

If we do nothing, this is going to continue to explode. If we do nothing, I say to my friend from Florida, we are going to see Children's Hospital bills not at the $2 million a year it costs to fill out reports today, but $10 million a year in the coming years. We are going to see the continued explosion of the health care bureaucracy in our country.

Mr. President, earlier this morning, one of the lead speakers, a very good speaker, a very good Senator, a good friend, the vice chairman of the Senate Special Committee on Aging, a real addition, a good addition to this body, stated—and I cannot quote him exactly—our friend, Senator COHEN, said he did not know why the newspaper headlines this morning "blamed us, the Republicans, for slowing down the health care bill" or "impeding the health care bill." I do not know exactly the term he used.

Well, I do not know why my friend the junior Senator from Maine, Senator COHEN, was surprised, because only last Wednesday on the floor of the Senate it was Senator PHIL GRAMM, and I quote, who declared "No one person will be able to comprehend the entire bill by next week," so he said he will divide up the measure, assign sections to individual GOP Senators, and have them explain their designated positions on the floor. He said then that process, and I quote, "will take a week, and," he said, "after that, the bill is dead."

"After that, the bill is dead."

So why would our friend from Maine be surprised to see that now the newspapers or the press people, the media, might be accusing or implying that the Republican side of the aisle would like to slow down and ultimately kill this bill.

Our friend from Utah, Senator BENNETT, spoke this afternoon—he gave a very, very good speech, I thought. He quoted from Newsweek regarding the so-called Mitchell bill and the Clinton plan, et cetera. But what he did not state was that Newsweek, in the same article, predicted, and I quote, Mr. President, "The Dole plan will increase premiums for middle-class people and could increase the number of uninsured."

What we are talking about, Mr. President, is 30 million people uninsured, left out of the system, forgotten, run away from should the Dole plan become law.

Mr. President, the other day—and I have used this before; this will be the second time—when we talked about delaying the vote, delaying consideration, stopping now and coming back in September, stopping now and coming back next year, when we do all of this, Mr. President, what I think we were saying is that we are giving up. I do not believe we can give up. I believe that we have to work harder. I do believe that we have to try to achieve a bipartisan proposal that we can take to the American people and say this is a better system than we have now.

When I thought about how to conjure up all the resources of the Senate, I added up the number of years that collectively all of us, all 100 of us that sit in this Chamber on a daily basis, how many years of Senate service have we had collectively. The answer is 1,236 years. I have been here 15 years. Senator THURMOND, I think, has been here over 35 or 36 years. Senator HATCH over there has been here over 20 years. Senator DASCHLE has been here since 1986, so he has not been here quite a decade.

But you add all of our service up together and, Mr. President, it is 12 centuries, over 12 centuries of public service in the U.S. Senate. And somehow I believe, with 12 centuries of experience, we do have the resources, we do have the ability; and hopefully, we have the will to come forward with a proposal that we can support, that we can take to the American people, and that we can be proud of as an institution.

Mr. President, I know that the time is late.

I know that we are all ready to go home. In fact, I would like to go home, Mr. President, and catch the last 30 or 40 minutes of the PGA Golf Tournament. That is where I would rather be this afternoon.

But I want you to know, Mr. President, it has been a high honor and a privilege to be here working with my colleagues today, this week, and this weekend on this proposal. We are going to continue to work on it until we do it, until we do it right. And we can do it, and we must do it, because if we do not, we will have failed our country, we will have failed our children, and we will have failed their children.

Mr. President, I thank the Chair, and I yield the floor.

Mr. DASCHLE addressed the Chair.

The PRESIDING OFFICER. The Senator from South Dakota.

Mr. DASCHLE. Mr. President, let me commend the distinguished Senator from Arkansas for an excellent statement. He has been a student of this issue now for many years. He is a member of the Finance Committee. He has

represented those of us who favor strongly the Mitchell bill.

In closing our debate this afternoon, we thank him for his contribution, participation, leadership, and commend him especially for the excellent statement he has just made.

NATIONAL BREAST CANCER AWARENESS MONTH

The text of the joint resolution (S.J. Res. 185) to designate October 1994 as "National Breast Cancer Awareness Month," as passed by the Senate on August 12, 1994, is as follows:

S.J. RES. 185

Whereas breast cancer will strike an estimated 182,000 women and 1,000 men in the United States in 1994;

Whereas the risk of developing breast cancer increases as a woman grows older;

Whereas breast cancer is the second leading cause of cancer death in women, and will kill an estimated 46,000 women and 300 men in 1994;

Whereas the 5-year survival rate for localized breast cancer has risen from 78 percent in the 1940's to over 90 percent today;

Whereas most breast cancers are detected by the woman herself;

Whereas educating both the public and health care providers about the importance of early detection will result in reducing breast cancer mortality;

Whereas appropriate use of screening mammography, in conjunction with clinical examination and breast self-examination, can result in the detection of many breast cancers early in their development and increase the survival rate to nearly 100 percent;

Whereas data from controlled trials clearly demonstrate that deaths from breast cancer are significantly reduced in women who have been screened by mammography;

Whereas many women are reluctant to have screening mammograms for a variety of reasons, such as the cost of testing, lack of information, or fear;

Whereas access to screening mammography is directly related to socioeconomic status;

Whereas increased awareness about the importance of screening mammography will result in the procedure being regularly requested by the patient and recommended by the health care provider; and

Whereas it is projected that more women will use this lifesaving test as it becomes increasingly available and affordable: Now, therefore, be it

Resolved by the Senate and House of Representatives of the United States of America in Congress assembled, That October 1994 is designated as "National Breast Cancer Awareness Month" and the President is authorized and requested to issue a proclamation calling upon the people of the United States to observe the month with appropriate programs and activities.

CRIME PREVENTION MONTH

The text of the joint resolution (S.J. Res. 192) to designate October 1994 as "Crime Prevention Month," as passed by the Senate on August 12, 1994, is as follows:

S.J. RES. 192

Whereas crime prevention improves the quality of life in every community;

Whereas crime prevention is a cost-effective answer to the problems caused by crime, drug abuse, and fear of crime;

Whereas crime prevention is central to a sound criminal justice system at Federal, State, and local levels;

Whereas millions of United States citizens have demonstrated that by working together, they can reduce crime, drug abuse, and fear of crime;

Whereas all people of the United States, from preschoolers to senior citizens, can help themselves, their families, and their neighborhoods prevent crime and build safer, more caring communities;

Whereas it is important to honor annually those individuals throughout society who work to prevent crime and to build and sustain communities; and

Whereas the National Citizens' Crime Prevention Campaign (featuring McGruff the Crime Dog and sponsored by the Department of Justice, the Crime Prevention Coalition, and the National Crime Prevention Council) encourages effective partnerships to reduce crime and to improve life throughout the Nation: Now, therefore, be it

Resolved by the Senate and House of Representatives of the United States of America in Congress assembled, That October 1994 is designated "Crime Prevention Month", and the President is authorized and requested to issue a proclamation calling upon the people of the United States to observe the month with appropriate ceremonies and activities.

YEAR OF THE GRANDPARENT

The text of the joint resolution (S.J. Res. 198) designating 1995 as "Year of the Grandparent," as passed by the Senate on August 12, 1994, is as follows:

S.J. RES. 198

Whereas grandparents bring a tremendous amount of love and power for good into the lives of their grandchildren;

Whereas grandparents, in partnership with parents, help deepen every child's roots and strengthen every child's wings so that every child may soar into adulthood with a glad heart and a confident spirit;

Whereas grandparents are a strong and important voice in support of the happiness and well-being of children;

Whereas grandparents often serve as the primary caregivers for their grandchildren, providing a stable and supportive home environment;

Whereas grandparents should be acknowledged for the important role they play within families, and for the many and varied contributions they make to enhance and further the value of the family and family traditions;

Whereas public awareness of and appreciation for the contributions of grandparents should be strengthened;

Whereas grandparents should be encouraged to continue as a vital force in the shaping of American families today and into the future;

Whereas the Nation acknowledges the contributions of grandparents by celebrating National Grandparents Day each September; and

Whereas there should be a year-long national celebration of grandparents and grandparenting: Now, therefore, be it

Resolved by the Senate and House of Representatives of the United States of America in Congress assembled, That 1995 is designated the "Year of the Grandparent", and the President is authorized and requested to issue a proclamation calling on the people of the United States to observe that year with appropriate programs, ceremonies, and activities.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mr. MITCHELL (for himself and Mr. DOLE):

S. Res. 248. A resolution to direct the Senate Legal Counsel to appear as amicus curiae in the name of the Senate in United States versus Durenberger; considered and agreed to.

ADDITIONAL COSPONSORS

SENATE JOINT RESOLUTION 215

At the request of Mr. DOLE, the names of the Senator from Colorado [Mr. BROWN], the Senator from New York [Mr. D'AMATO], the Senator from Arizona [Mr. DECONCINI], the Senator from New Mexico [Mr. DOMENICI], the Senator from California [Mrs. FEINSTEIN], the Senator from Alabama [Mr. HEFLIN], the Senator from Maryland [Ms. MIKULSKI], the Senator from Alaska [Mr. MURKOWSKI], and the Senator from Pennsylvania [Mr. SPECTER] were added as cosponsors of Senate Joint Resolution 215, a joint resolution designating September 5, 1994, Labor Day, as "Try American Day."

SENATE RESOLUTION 243

At the request of Mr. LOTT, the name of the Senator from Alabama [Mr. HEFLIN] was added as a cosponsor of Senate Resolution 243, a resolution recognizing the Realtors Land Institute on the occasion of its 50th anniversary.

SENATE RESOLUTION 248—TO DIRECT THE SENATE LEGAL COUNSEL TO APPEAR AS AMICUS CURIAE IN THE NAME OF THE SENATE IN UNITED STATES VERSUS DURENBERGER

Mr. MITCHELL (for himself and Mr. DOLE) submitted the following resolution; which was considered and agreed to:

S. RES. 248

Whereas, in the case of *United States* v. *Durenberger*, No. 94-3105, pending on appeal in the United States Court of Appeals for the District of Columbia Circuit, the powers and responsibilities of Congress and the relationship among the branches of government have been placed in issue;

Whereas, pursuant to sections 703(c), 706(a), and 713(a) of the Ethics in Government Act of 1978, 2 U.S.C. 288b(c), 288e(a), and 288*l*(a) (1988), the Senate may direct its Counsel to appear as amicus curiae in the name of the Senate in any legal action which places in issue the powers and responsibilities of Congress under the Constitution: Now, therefore, be it

Resolved, That the Senate Legal Counsel is directed to appear as amicus curiae in the name of the Senate in *United States* v. *Durenberger*, for the limited purpose of requesting

the Court to give plenary consideration to the contentions of the United States and Senator Durenberger in regard to the separation of powers questions presented by the appeal.

AMENDMENTS SUBMITTED

DIETARY SUPPLEMENT HEALTH AND EDUCATION ACT OF 1994

HATCH (AND HARKIN) AMENDMENT NO. 2562

Mr. HATCH (for himself and Mr. HARKIN) proposed an amendment to the bill (S. 784) to amend the Federal Food, Drug, and Cosmetic Act to establish standards with respect to dietary supplements, and for other purposes as follows:

Strike out all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "Dietary Supplement Health and Education Act of 1994".

SEC. 2. FINDINGS AND PURPOSE.

(a) FINDINGS.—Congress finds that—

(1) improving the health status of United States citizens ranks at the top of the national priorities of the Federal Government;

(2) the importance of nutrition and the benefits of dietary supplements to health promotion and disease prevention have been documented increasingly in scientific studies;

(3)(A) there is a definitive link between the ingestion of certain nutrients or dietary supplements and the prevention of chronic diseases such as cancer, heart disease, and osteoporosis; and

(B) clinical research has shown that several chronic diseases can be prevented simply with a healthful diet, such as a diet that is low in fat, saturated fat, cholesterol, and sodium, with a high proportion of plant-based foods;

(4) healthful diets may mitigate the need for expensive medical procedures, such as coronary bypass surgery or angioplasty;

(5) preventive health measures, including education, good nutrition, and appropriate use of safe nutritional supplements will limit the incidence of chronic diseases, and reduce long-term health care expenditures;

(6)(A) promotion of good health and healthy lifestyles improves and extends lives while reducing health care expenditures; and

(B) reduction in health care expenditures is of paramount importance to the future of the country and the economic well-being of the country;

(7) there is a growing need for emphasis on the dissemination of information linking nutrition and long-term good health;

(8) consumers should be empowered to make choices about preventive health care programs based on data from scientific studies of health benefits related to particular dietary supplements;

(9)(A) national surveys have revealed that almost 50 percent of the 260,000,000 Americans regularly consume dietary supplements of vitamins, minerals, or herbs as a means of improving their nutrition; and

(B) nearly all consumers indicate that dietary supplements should not be regulated as drugs;

(10) studies indicate that consumers are placing increased reliance on the use of non-traditional health care providers to avoid the excessive costs of traditional medical services and to obtain more holistic consideration of their needs;

(11) the United States will spend over $1,000,000,000,000 on health care in 1994, which is about 12 percent of the Gross National Product of the United States, and this amount and percentage will continue to increase unless significant efforts are undertaken to reverse the increase;

(12)(A) the nutritional supplement industry is an integral part of the economy of the United States;

(B) the industry consistently projects a positive trade balance; and

(C) the estimated 600 dietary supplement manufacturers in the United States produce approximately 4,000 products, with total annual sales of such products alone reaching at least $4,000,000,000;

(13) although the Federal Government should take swift action against products that are unsafe or adulterated, the Federal Government should not take any actions to impose regulatory barriers limiting or slowing the flow of safe products and needed information to consumers;

(14) dietary supplements are safe within a broad range of intake, and safety problems with the supplements are relatively rare; and

(15)(A) legislative action that protects the right of access of consumers to safe dietary supplements is necessary in order to promote wellness; and

(B) a rational Federal framework must be established to supersede the current ad hoc, patchwork regulatory policy on dietary supplements.

(b) PURPOSE.—It is the purpose of this Act to—

(1) improve the health status of the people of the United States and help constrain runaway health care spending by ensuring that the Federal Government erects no regulatory barriers that impede the ability of consumers to improve their nutrition through the free choice of safe dietary supplements;

(2) clarify that—

(A) dietary supplements are not drugs or food additives;

(B) dietary supplements should not be regulated as drugs;

(C) regulations relating to food additives are not applicable to dietary supplements and their ingredients used for food additive purposes, including stabilizers, processing agents, or preservatives; and

(D) the burden of proof is on the Food and Drug Administration to prove that a product is unsafe before it can be removed from the marketplace;

(3) establish a new definition of a dietary supplement that differentiates dietary supplements from conventional foods, while recognizing the broad range of food ingredients used to supplement the diet;

(4) strengthen the current enforcement authority of the Food and Drug Administration by providing to the Administration additional mechanisms to take enforcement action against unsafe or fraudulent products;

(5) establish a series of labeling requirements that will provide consumers with greater information and assurance about the quality and content of dietary supplements, while at the same time assuring the consumers the freedom to use the supplements of their choice;

(6) provide new administrative and judicial review procedures to affected parties if the Food and Drug Administration takes certain actions to enforce dietary supplement requirements; and

(7) establish a Commission on Dietary Supplement Labels within the executive branch to develop recommendations on a procedure to evaluate health claims for dietary supplements and provide recommendations to the President and the Congress.

SEC. 3. DEFINITIONS.

(a) DEFINITION OF CERTAIN FOODS AS DIETARY SUPPLEMENTS.—Section 201 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321) is amended by adding at the end the following:

"(ff) The term 'dietary supplement' means—

"(1) a product intended to supplement the diet by increasing the total dietary intake that bears or contains one or more of the following dietary ingredients:

"(A) a vitamin;

"(B) a mineral;

"(C) an herb or other botanical;

"(D) an amino acid;

"(E) another dietary substance for use by man to supplement the diet by increasing the total dietary intake; or

"(F) a concentrate, metabolite, constituent, extract, or combination of any ingredient described in clause (A), (B), (C), (D), (E) or (F);

"(2) a product that—

"(A)(i) is intended for ingestion in a form described in section 411(c)(1)(B)(i); or

"(ii) complies with section 411(c)(1)(B)(ii); and

"(B) is not represented for use as a conventional food or as a sole item of a meal or the diet; and

"(C) is labeled as a dietary supplement.".

(b) EXCLUSION FROM DEFINITION OF DRUG.—Section 201(g) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(g)) is amended by adding at the end the following new subparagraph:

"(3) The term 'drug' does not include a dietary supplement as defined in paragraph (ff), except that—

"(A) an article that is approved as a new drug, certified as an antibiotic (under section 355 or 357), or licensed as a biologic (under section 351 of the Public Health Service Act (42 U.S.C. 262 et seq.)) and was, prior to such approval, certification or license, marketed as a dietary supplement or as a food, may continue to be offered for sale as a dietary supplement unless the Secretary has issued a regulation, after notice and comment, finding that the article when used as or in a dietary supplement under the conditions of use and dosages set forth in the labeling for such dietary supplement, is unlawful under section 402(f); and

"(B) an article that is approved as a new drug, certified as an antibiotic (under section 355 or 357), or licensed as a biologic (under section 351 of the Public Health Service Act (42 U.S.C. 262 et seq.)) and was not prior thereto marketed as a dietary supplement or as a food, may not be considered as a dietary ingredient or dietary supplement unless the Secretary has issued a regulation, after notice and comment, finding that the article would be lawful under section 402(f) under the conditions of use and dosages set forth in the recommended labeling for such article.".

(c) EXCLUSION FROM DEFINITION OF FOOD ADDITIVE.—Section 201(s) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(s)) is amended—

(1) by striking "or" at the end of subparagraph (4);

(2) by striking the period at the end of subparagraph (5) and inserting "; or"; and

(3) by adding at the end the following new subparagraph:

"(6) an ingredient described in paragraph (ff) in, or intended for use in, a dietary supplement.".

(d) FORM OF INGESTION.—Section 411(c)(1)(B) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 350(c)(1)(B)) is amended—

(1) in clause (i), by inserting "powder, softgel, gelcap," after "capsule,"; and

(2) in clause (ii), by striking "does not simulate and".

SEC. 4. SAFETY OF DIETARY SUPPLEMENTS AND BURDEN OF PROOF ON FDA.

Section 402 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 342) is amended by adding at the end the following:

"(f) If it is a dietary supplement that—

"(1) the Secretary finds, after rulemaking, presents a substantial and unreasonable risk of illness or injury under conditions of use recommended or suggested in labeling;

"(2) the Secretary declares to pose an imminent and substantial hazard to public health or safety, except that the authority to make such declaration shall not be delegated and the Secretary shall promptly thereafter convene rulemaking pursuant to section 701(e), (f), and (g) to affirm or withdraw the declaration; or

"(3) is or contains a dietary ingredient that renders it adulterated under paragraph (a)(1) under the conditions of use recommended or suggested in the labeling of such dietary supplement.

In any proceeding under this section, the United States bears the burden of proof on each element to show that a dietary supplement is adulterated.".

SEC. 5. DIETARY SUPPLEMENT CLAIMS.

(a) SUPPLEMENT CLAIMS.—Chapter IV of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 341 et seq.) is amended by inserting after section 403A the following new section:

"DIETARY SUPPLEMENT LABELING EXEMPTIONS

"SEC. 403B. An article, another publication, a chapter in books, or the official abstract of a peer-reviewed scientific publication that appears in the article and was prepared by the author or the editors of the publication, reprinted in its entirety, shall not be defined as labeling when used in connection with the sale of dietary supplements to consumers when it—

"(1) is not false or misleading;

"(2) does not promote a particular brand of a dietary supplement;

"(3) is displayed or presented, or is displayed or presented with other such items on the same subject matter, so as to present a balanced view of the available scientific information on a dietary supplement; and

"(4) if displayed in an establishment, is physically separate from the dietary supplements.

This section shall not apply to or restrict a retailer or wholesaler of dietary supplements in any way whatsoever in the sale of books or other publications as a part of the business of such retailer or wholesaler. In any proceeding under this section, the burden of proof shall be on the United States to establish that an article or other such matter is false or misleading.".

SEC. 6. STATEMENTS OF NUTRITIONAL SUPPORT.

Section 403(r)(1) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 343(r)(1)) is amended by adding the following new sentence at the end: "For purposes of this subparagraph, a statement for a dietary supplement shall not be considered a claim of the relationship of a nutrient or dietary ingredient to a disease or health-related condition if the statement does not claim to diagnose, prevent, mitigate, treat, or cure a specific disease or class of diseases. A statement for a dietary supplement may be made if the statement claims a benefit related to a classical nutrient deficiency disease and discloses the prevalence of such disease in the United States, describes the role of a nutrient or dietary ingredient intended to affect the structure or function in humans, characterizes the documented mechanism by which a nutrient or dietary ingredient acts to maintain such structure or function, or describes general well-being from consumption of a nutrient or dietary ingredient.".

SEC. 7. CONFORMING AMENDMENTS.

(a) SECTION 201.—The next to the last sentence of section 201(g)(1) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(g)(1)) (as amended by section 3(b)) is amended to read as follows: "A food or dietary supplement for which a claim, subject to section 403(r)(1)(B) and 403(r)(3) or section 403(r)(1)(B) and 403(r)(5)(D), is made in accordance with the requirements of section 403(r) is not a drug solely because the label or the labeling contains such a claim. A food, dietary ingredient, or dietary supplement for which a truthful and nonmisleading statement is made in accordance with section 403(r)(1) is not a drug solely because the label or the labeling contains such a statement.".

(b) SECTION 403.—Section 403 (21 U.S.C. 343) is amended by adding at the end the following:

"A dietary supplement shall not be deemed misbranded solely because its label or labeling contains directions or conditions of use or warnings.".

SEC. 8. ADMINISTRATIVE AND JUDICIAL REVIEW.

The Federal Food, Drug, and Cosmetic Act is amended by adding at the end of chapter III (21 U.S.C. 331 et seq.) the following new section:

"SEC. 311. WARNING LETTERS.

"Any warning letter or similar written threat of enforcement under the Federal Food, Drug, and Cosmetic Act constitutes final agency action for the purpose of obtaining judicial review under chapter 7 of title 5, United States Code, if the matter with respect to such letter or threat is not resolved within 60 days from the date such letter or threat is delivered to any person subject to this Act. In any proceeding for judicial review of a warning letter or similar written threat of enforcement under the Act, the United States bears the burden of proof on each element of each alleged violation of law described.".

SEC. 9. WITHDRAWAL OF THE REGULATIONS AND NOTICE.

(a) IN GENERAL.—The advance notice of proposed rulemaking concerning dietary supplements published in the Federal Register of June 18, 1993 (58 FR 33690–33700), the notices of proposed rulemaking concerning nutrition labeling for dietary supplements and nutrient content claims for dietary supplements published in the Federal Register of June 18, 1993 (58 FR 33715–33731 and 58 FR 33731–33751), and the final rules and notices published in the Federal Register of January 4, 1994 concerning nutrition labeling for dietary supplements and nutrient content claims for dietary supplements (59 FR 354–378 and 378–395) are null and void and of no force or effect insofar as they apply to dietary supplements. Final regulations and notices published in the Federal Register of January 4, 1994 concerning health claims for dietary supplements under the Nutrition Labeling and Education Act of 1990 (59 FR 395–426) shall not be affected by this section and shall remain in effect until 120 days after the date of the submission of the final report of the Commission established under section 11 to the President and to Congress, or 28 months after the date of enactment of this Act, whichever is earlier.

(b) NOTICE OF REVOCATION.—The Secretary of Health and Human Services shall publish notices in the Federal Register to revoke all of the items declared to be null and void and of no force or effect under subsection (a).

(c) ISSUANCE OF REGULATIONS.—Notwithstanding any provision of the Nutrition Labeling and Education Act of 1990—

(1) no regulation is required to be issued pursuant to such Act with respect to dietary supplements of vitamins, minerals, herbs, amino acids, or other similar nutritional substances; and

(2) no regulation that is issued in whole or in part pursuant to such Act shall have any force or effect with respect to any dietary supplement of vitamins, minerals, herbs, amino acids, or other similar nutritional substances unless such regulation is issued pursuant to rulemaking proceedings that are initiated by an advance notice of proposed rulemaking that is published no earlier than 2 years after the date of enactment of this Act, and followed by, at least, a notice of proposed rulemaking prior to issuance of the final regulation, except insofar as the regulation authorizes the use of labeling about calcium, folic acid, or other matters and does not prohibit the use of any labeling.

SEC. 10. DIETARY SUPPLEMENT INGREDIENT LABELING AND NUTRITION INFORMATION LABELING.

(a) MISBRANDED SUPPLEMENTS.—Section 403 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 343) is amended by adding at the end the following new paragraph:

"(s) If—

"(1) it is a dietary supplement; and

"(2)(A) the label or labeling of the supplement fails to list—

"(i) the name of each ingredient of the supplement that is described in section 201(ff); and

"(ii)(I) the quantity of each such ingredient; or

"(II) with respect to a proprietary blend of such ingredients, the total quantity of all ingredients in the blend;

"(B) the label or labeling of the dietary supplement fails to identify the product by using the term 'dietary supplement', which term may be modified with the name of such an ingredient;

"(C) the supplement contains an ingredient described in section 201(ff) (1)(C), and the label or labeling of the supplement fails to identify any part of the plant from which the ingredient is derived;

"(D) the supplement—

"(i) is covered by the specifications of an official compendium;

"(ii) is represented as conforming to the specifications of an official compendium; and

"(iii) fails to so conform; or

"(E) the supplement—

"(i) is not covered by the specifications of an official compendium; and

"(ii)(I) fails to have the identity and strength that the supplement is represented to have; or

"(II) fails to meet the quality (including tablet or capsule disintegration), purity, or compositional specifications, based on validated assay or other appropriate methods, that the supplement is represented to meet.".

(b) SUPPLEMENT LISTING ON NUTRITION LABELING.—Section 403(q)(1) of the Federal

Food, Drug, and Cosmetic Act (21 U.S.C. 343(q)(1)) is amended by adding at the end the following: "A dietary supplement may bear on the nutrition label or in labeling a listing and quantity of ingredients that have not been deemed essential nutrients by the Secretary if such ingredients are prominently identified as not having been shown to be essential or not having an established daily value.".

(c) DIETARY SUPPLEMENT LABELING EXEMPTIONS.—Section 403(q)(5) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 343(q)(5)) is amended by adding at the end the following new clause:

"(H) The labels of dietary supplements shall not be required to bear the nutrition information under subparagraph (1), but shall be required to list immediately above the ingredient listing the amount of nutrients required by the Secretary to be listed pursuant to clause (C), (D) or (E) of subparagraph (1) or clause (A) of subparagraph (2) that are present in significant amounts in the supplement.".

(d) VITAMINS AND MINERALS.—Section 411(b)(2) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 350(b)(2)) is amended—

(1) by striking "vitamins and minerals" and inserting "dietary supplement ingredients described in section 201(ff)";

(2) by striking "(2)(A)" and inserting "(2)"; and

(3) by striking subparagraph (B).

SEC. 11. COMMISSION ON DIETARY SUPPLEMENT LABELS.

(a) ESTABLISHMENT.—There shall be established as an independent agency within the executive branch a commission to be known as the Commission on Dietary Supplement Labels (hereafter in this section referred to as the "Commission").

(b) MEMBERSHIP.—

(1) COMPOSITION.—The Commission shall be composed of 7 members who shall be appointed by the President.

(2) EXPERTISE REQUIREMENT.—The members of the Commission shall consist of individuals with expertise and experience in dietary supplements and in the manufacture, regulation, distribution, and use of such supplements. At least three of the members of the Commission shall be qualified by scientific training and experience to evaluate the benefits to health of the use of dietary supplements and one of such three members shall have experience in pharmacognosy, medical botany, traditional herbal medicine, or other related sciences. No member of the Commission shall be biased against dietary supplements.

(c) FUNCTIONS OF THE COMMISSION.—The Commission shall conduct a study on, and provide recommendations for, the regulation of label claims for dietary supplements, including procedures for the evaluation of such claims. In making such recommendations, the Commission shall evaluate how best to provide truthful and nonmisleading information to consumers so that such consumers may make informed health care choices for themselves and their families.

(d) REPORTS AND RECOMMENDATIONS.—

(1) FINAL REPORT REQUIRED.—Not later than 24 months after the date of enactment of this Act, the Commission shall prepare and submit to the President and to the Congress a final report on the study required by this section.

(2) RECOMMENDATIONS.—The report described in paragraph (1) shall contain such recommendations, including recommendations for legislation, as the Commission deems appropriate.

(e) ADMINISTRATIVE POWERS OF THE COMMISSION.—

(1) HEARINGS.—The Commission may hold hearings, sit and act at such times and places, take such testimony, and receive such evidence as the Commission considers advisable to carry out the purposes of this section.

(2) INFORMATION FROM FEDERAL AGENCIES.—The Commission may secure directly from any Federal department or agency such information as the Commission considers necessary to carry out the provisions of this section.

(3) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section.

SEC. 12. GOOD MANUFACTURING PRACTICES.

Section 402 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 342) (as amended by section 4) is further amended by adding at the end the following:

"(g)(1) If it is a dietary supplement and it has been prepared, packed, or held under conditions that do not meet current good manufacturing practice regulations issued by the Secretary under subparagraph (2).

"(2) The Secretary may by regulation prescribe good manufacturing practices for dietary supplements. Such regulations shall be modeled after current good manufacturing practice regulations for food and may not impose standards for which there is no current and generally available analytical methodology. No standard of current good manufacturing practice may be imposed unless such standard is included in a regulation promulgated after notice and opportunity for comment in accordance with the Administrative Procedure Act.".

SEC. 13. OFFICE OF DIETARY SUPPLEMENTS.

(a) IN GENERAL.—Title IV of the Public Health Service Act is amended by inserting after section 486 (42 U.S.C. 287c–3) the following:

"Subpart 4—Office of Dietary Supplements

"SEC. 486E. DIETARY SUPPLEMENTS.

"(a) ESTABLISHMENT.—The Secretary shall establish an Office of Dietary Supplements within the National Institutes of Health.

"(b) PURPOSE.—The purposes of the Office are—

"(1) to explore more fully the potential role of dietary supplements as a significant part of the efforts of the United States to improve health care; and

"(2) to promote scientific study of the benefits of dietary supplements in maintaining health and preventing chronic disease and other health-related conditions.

"(c) DUTIES.—The Director of the Office of Dietary Supplements shall—

"(1) conduct and coordinate scientific research within the National Institutes of Health relating to dietary supplements and the extent to which the use of dietary supplements can limit or reduce the risk of diseases such as heart disease, cancer, birth defects, osteoporosis, cataracts, or prostatism;

"(2) collect and compile the results of scientific research relating to dietary supplements, including scientific data from foreign sources or the Office of Alternative Medical Practice;

"(3) serve as the principal advisor to the Secretary and to the Assistant Secretary for Health, and to provide advice to the Director of the National Institutes of Health, the Director of the Centers for Disease Control and Prevention, and the Commissioner of Food and Drugs, on issues relating to dietary supplements including—

"(A) dietary intake regulations;

"(B) the safety of dietary supplements;

"(C) claims characterizing the relationship between—

"(i) dietary supplements; and

"(ii)(I) prevention of disease or other health-related conditions; and

"(II) maintenance of health; and

"(D) scientific issues arising in connection with the labeling and composition of dietary supplements;

"(4) compile a database of scientific research on dietary supplements and individual nutrients; and

"(5) coordinate funding relating to dietary supplements for the National Institutes of Health.

"(d) DEFINITION.—As used in this section, the term 'dietary supplement' has the meaning given the term in section 201(ff) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(ff)).

"(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $5,000,000 for fiscal year 1994 and such sums as may be necessary for each subsequent fiscal year.".

(b) CONFORMING AMENDMENT.—Section 401(b)(2) of the Public Health Service Act (42 U.S.C. 281(b)(2)) is amended by adding at the end the following:

"(E) The Office of Dietary Supplements.".

TO AMEND THE FEDERAL FOOD, DRUG, AND COSMETIC ACT

Mr. DASCHLE. Mr. President, I ask unanimous consent that the Labor Committee be discharged from further consideration of S. 784, a bill to establish standards with respect to dietary supplements, and that the Senate proceed to its immediate consideration.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will report.

The bill clerk read as follows:

A bill (S. 784) to amend the Federal Food, Drug, and Cosmetic Act to establish standards with respect to dietary supplements, and for other purposes.

The PRESIDING OFFICER. Is there objection to the immediate consideration of the bill?

There being no objection, the Senate proceeded to consider the bill.

AMENDMENT NO. 2562

Mr. HATCH. Mr. President, I send to the desk a substitute amendment on behalf of myself and Senator HARKIN, and I ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The bill clerk read as follows:

The Senator from Utah [Mr. HATCH], for himself and Mr. HARKIN, proposes an amendment numbered 2562.

Mr. HATCH. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

(The text of the amendment is printed in today's RECORD under "Amendments Submitted.")

Mr. KENNEDY. Mr. President, I am concerned about several provisions of

S. 784 in its present form. I am hopeful, however, that this action by the Senate will bring us closer to enacting the kind of worthwhile compromise that is needed to protect the public health while dealing with the legitimate concerns of the large numbers of citizens who use dietary supplements and who deserve to have them available.

Recent Federal legislation, especially the Nutrition Labeling and Education Act, has created a great deal of concern and uncertainty about the status of these products. I believe all of us agree on the need to provide consumers with freedom of choice and access to these products. I believe we also agree on the need for responsible precautions to protect the public against dangerous products and false health claims.

There continue to be differences among us as to how to achieve these goals most effectively. For example, the Hatch legislation offers a definition of dietary supplements that many feel is too broad. It will allow certain products which are treated as prescription drugs in other countries, or as unapproved drugs in this country, to be treated as dietary supplements and therefore subjected to inadequate safeguards.

I addition, for safety purposes, I believe the legislation should contain a protective safety standard to assure the ability of the Food and Drug Administration to act quickly to remove products that are dangerous.

Similar concerns exist with respect to other issues, such as the accuracy of health claims made on behalf of dietary supplements, and the use of promotional literature in connection with the distribution of these products.

To deal with these concerns about the legislation in its present form, Members of both the Senate and the House of Representatives have been engaged in numerous bipartisan meetings over the past several months. We have made significant progress in refining the issues and working out a consensus solution that all of us can support.

I continue to hope that a reasonable compromise can be reached that will protect the public health against dangerous or fraudulent products, without interfering with the large number of legitimate dietary supplements that are now available or that will become available in the future as a result of the remarkable scientific progress that is taking place and the greater and greater knowledge we are acquiring about diets and health.

The issues that divide us are not insurmountable. We all have a responsibility to ensure a fair resolution of these concerns. I hope we can continue to work with our Senate and House colleagues to expedite final action on this measure.

DIETARY SUPPLEMENT HEALTH AND EDUCATION ACT

Mr. HATCH. Mr. President, this is a momentous day in the U.S. Senate.

Today, we honor the wishes of 100 million people, consumers of dietary supplements, people who simply want the ability to lead healthy lifestyles without the constant intervention of one tiny agency which is possessed by a regulatory zeal equaling none.

It is entirely appropriate that we consider the Dietary Supplement Health and Education Act today, as the Senate completes another day of debate on the health care reform legislation. For there is no bill which can lead to improved health more than S. 784.

The substitute that I offer today embodies the text of the Dietary Supplement Health and Education Act as approved by the Labor and Human Resources Committee on May 11, with several important changes negotiated by Senator HARKIN and myself in response to concerns raised by several Senators immediately prior to the markup.

Our overwhelming consideration in considering this legislation today is that the legislative session is rapidly drawing to a close. The specter of our all-consuming debate on health care reform hangs over us. That debate will surely continue for days, if not weeks.

In the interim, we have a legislative proposal which is cosponsored by 66 Senators, two-thirds of this body, and supported by many, many more.

In the House, the counterpart legislation authored by our esteemed colleague, Representative BILL RICHARDSON, has over 250 cosponsors. Unfortunately, that bill has not been marked up yet, either in subcommittee or full committee.

Mr. President, Senate staff has been meeting on almost a daily basis with the staff of Chairmen DINGELL and WAXMAN; we have made some progress, but we have not been able to bring the negotiations to a conclusion after several weeks of discussion.

I am very appreciative of the great amount of time the House staff has devoted to this effort, especially at such a busy time in our legislative agenda. There is no question they have a strong desire to work this out.

Chairman DINGELL's most able counsel, Kay Holcombe, one of the best staffers on Capitol Hill in my estimation, and Chairman WAXMAN's counsel, Bill Schultz, a superb food and drug lawyer, have gone out of their way to make the time for these negotiating sessions. For that, I—and I believe I am speaking for Senator HARKIN as well—owe a great debt of gratitude.

Nevertheless, we have to realize that the situation is very different in the Senate with a bill which has been reported by the Labor and Human Resources Committee on a 13 to 4 vote. I have the greatest respect for our House colleagues, but I recognize that they do have differing views about the regulation of products which fall under the purview of the Food and Drug Administration. The issues surrounding the regulation of dietary supplements are tremendously complicated, and there are many details we have to work out.

I want to make very, very clear, that we recognize there will be no final bill without the participation and agreement of our House colleagues. We are not intending to act unilaterally here, but rather to show the Senate's eagerness to move this issue to a conclusion.

After this amendment passes, as I know it will, I intend that our staffs continue negotiations with the House, in an effort to wrap this up. I will be available any time, day or night, to meet with our House colleagues, as I am sure is the case with Senator HARKIN.

This dialog with the House is one I wish to continue; I want to make that abundantly clear.

As I mentioned, the language we offer today differs from the Dietary Supplement Health and Education Act in several crucial ways which I will outline.

As you know, S. 784 makes clear that dietary supplements are not food additives or drugs, and that the burden of proof shall be on the FDA to prove that a product is unsafe. That basic premise does not change.

Drafters of the legislation, though, were criticized for a definition of dietary supplement which some felt was overly broad. We have tried to tighten that up.

Some then believed that the language would allow drugs such as taxol to be marketed in the United States as dietary supplements. Senator HARKIN and I worked for some time after the markup to resolve that issue, and the language we present today addresses that concern.

Other concerns were raised about the safety standard in the bill; that is, the standard which FDA uses to gauge whether a product is unsafe and thus should be removed from the market.

I continue to believe that the safety standard in the law is adequate. However, in deference to concerns that FDA may not have the authority to remove potentially dangerous products from the market, we have inserted a provision giving the Secretary emergency authority to act against dietary supplements which pose an imminent and substantial public health hazard.

We took this language from a similar provision in the drug law.

Some have argued that this new provision would be ineffective, because the drug language has been in the statute since 1938 and has seldom been utilized.

I look at it the other way. The reason this emergency authority has been seldom used is that the threat of this tool is so effective; it is such a powerful enforcer that it doesn't need to be utilized to be effective.

Another issue about which much concern was expressed is health claims.

Under S. 784, as introduced, dietary supplement health labeling claims would be allowed as long as they are truthful and not misleading and are based on the totality of scientific evidence. Because of FDA's bias against dietary supplements and dietary supplement claims, I was not, and am not, comfortable in allowing the FDA the power to approve claims—simply because they won't approve claims, as history has shown.

However, in deference to concern raised by several of our colleagues, both on and off the Labor Committee, Senator HARKIN and I are willing to consider a fair claims process, on two conditions: First, that consumers will be guaranteed access to information about dietary supplements through truthful and nonmisleading third-party literature such as journals or newspaper articles; and second, dietary supplement manufacturers will be able to make so-called structure/function or nutrition support statements, statements about how a nutrient affects the structure or function of the body.

An example of a structure/function claim is, "Calcium builds strong bones." Manufacturers have the right to make such statements under current law, and our bill clarifies that they continue to have this right.

With respect to third-party literature, the Harkin-Hatch compromise states that truthful and nonmisleading information can be provided to consumers in connection with the marketing of dietary supplements, provided that information does not promote any specific product or brand, provided the information is balanced, and provided it is maintained in a location which is physically separate from the products.

It should be emphasized that these new provisions allowing the use of certain independent third-party literature in connection with the sale of dietary supplement products in no way detract from the right of a retail health food store or any other business or person to sell independently both dietary supplements and books or other literature about nutrients.

The United States Court of Appeals for the Second Circuit ruled in *United States* v. *Sterling Vinegar and Honey * * * and an Undetermined Number of Copies of * * * Books*, 333 F.2d 157—2nd Cir. 1964—that a health food store could, properly, sell both a honey-vinegar product and, separately, books about the purported health- and disease-related benefits of a honey-vinegar combination, without having the books be deemed to be labeling when there was no "integrated use" of the books and the honey-vinegar product by the store. That case remains good law, and nothing in this legislation would change it.

Instead, what the legislation would do would be to permit the use of certain types of third party literature in direct connection with the sale of dietary supplement products. The literature would need to meet certain criteria that would generally establish the independence and reliability of the material; that is, the bill would require: First, that any such item would need to be "not false or misleading"; second, that it "not promote a particular brand of dietary supplement"; third, that it be displayed or presented so as to present a "balanced view" of the available information; and fourth, that if displayed in a location in an establishment, it be displayed "physically separate" from the dietary supplements.

Thus, I want to make clear that our language in no way interferes with the current ability of retailers to maintain a library or literature section in their stores which contain both reference materials and materials for sale.

A major way in which this amendment differs from the original Dietary Supplement Health and Education Act is in the treatment of health claims.

This amendment makes clear that dietary supplements will be subject to the preapproval process and standard of Nutritional Labeling and Education Act for the 2-year period that a new, independent Commission determines the most appropriate process.

This is a major compromise, and I was not totally comfortable in agreeing to it. However, I do believe the provision is necessary if we are to get a bill signed this year. As long as the authority is time-limited and Congress has an ability to reexamine it in the future, I believe it is reasonable to include it in our compromise.

Two other changes are important to note.

At the request of our colleague from Washington, Senator MURRAY, we have included a provision requiring that all dietary supplements be labeled with an expiration date. Senator MURRAY's suggestion is a good improvement to our bill.

After S. 784 was introduced, the food industry expressed some concern that the language put them at a competitive disadvantage, since dietary supplement claims could be made under a lower standard than those for foods.

That situation is not the case under this substitute, since all dietary supplement claims during the 2-year period would be subject to the same process and standard as that for foods.

I am aware that some Members of this body sought additional provisions relating to foods in this bill. I sincerely regret that we could not bring together consensus on this matter in the Senate. Senator HARKIN and I tried very hard and we will keep working to pursue this in the House.

Finally, at the suggestion of Chairman DINGELL, the substitute supports the establishment of appropriate dietary supplement good manufacturing practice regulations. Dietary supplements currently are subject to the good manufacturing practices [GMP] requirements for foods.

We believe Chairman DINGELL raised a valid point that dietary supplements may require different manufacturing and quality controls and a provision addressing his concern is included.

The substitute continues other provisions contained in our original bill. One of those is the authorization for an Office of Dietary Supplements at the National Institutes of Health, so that we can encourage more focus on research into the health benefits of nutritional supplements.

Another is a provision allowing judicial review of FDA warning letters, if the issue giving rising to the letter is not resolved within 60 days. The bill makes clear that the provision only allows manufacturers to go to court to challenge the findings in the warning letter; it does not preclude the FDA from taking any action it finds necessary under law to resolve the situation.

Mr. President, I want to underscore here the wide range of support for this amendment.

Our efforts are supported by groups ranging from Citizens for Health, with chapters all throughout the Nation, to the Alliance for Aging Research, to the Utah Natural Products Alliance. Our substitute is supported by the National Nutritional Foods Association, the Nutritional Health Alliance, and the Council for Responsible Nutrition.

In particular, I want to cite the dedicated efforts of Citizens for Health, whose hundreds of members have worked tirelessly and unselfishly to make this an informed and successful debate. There is no question in my mind that the work of this citizen army makes today's victory possible.

Others have worked very closely with us and I want to recognize their special efforts, including the National Council for Improved Health, Michael Onstott and the others at the Alternative Treatment Committee of the AIDS Coalition to Unleash Power [ACT-UP], San Francisco, Dr. Julian Whitaker, a noted physician and president of the American Preventive Medical Association.

Let me also mention the valuable information that has been provided to me by several other individuals, including: the late Royden Brown, a leader in the alternative medicine community; Claire Farr, president of Claire Industries; Ken Murdock, chairman of Nature's Way; Richard Bizzaro, president of Wieder Foods; and Jeff Henricks, president of Solaray.

Finally, I want to cite the stellar testimony at our hearing by nutritionist and author Patricia Hausman, and by Dr. Michael Janson, who is a fellow and member of the board of directors of the American College for Advancement in

Medicine and the chairman of their scientific advisory committee.

These people and organizations have all done fabulous work in helping to bring the bill forward to the Senate floor, and I will be counting on them to help Representative RICHARDSON, Representative GALLEGLY, and me move the bill through the House as well.

These organizations recognize what two-thirds of the Senate has recognized: for over 30 years, the FDA has pursued a single-minded regulatory agenda which has stifled the ability of consumers to have access to safe dietary supplements and information about those supplements.

Despite a voluminous scientific record indicating the potential health benefits of dietary supplements, the Food and Drug Administration has pursued a heavy-handed enforcement agenda against nutritional supplements which has forced the Congress to intervene on two previous occasions, and yet again with adoption of this amendment.

In 1962, the FDA published regulations setting minimum and maximum levels for supplements. These regulations were withdrawn in the face of strong citizen protest.

Between 1966 and 1973, the agency issued proposed regulations on the labeling and content of dietary food products. FDA tried to classify vitamins as over-the-counter drugs if the product exceeded 150 percent of the recommended daily allowances [RDA]. Vitamins A and D would have been prohibited under most circumstances. Congress negated this action in 1976 when it approved the Proxmire/Rogers amendment to the Federal Food, Drug and Cosmetic Act.

Blocked by the Proxmire amendment, later in the 1970's, FDA tried to regulate vitamins by claiming they were toxic, and therefore their potencies could be regulated. The Federal courts rejected FDA's attempt to end-run the Proxmire.

In 1980, the FDA issued a proposed over-the-counter drug monograph for vitamins and minerals. The document supposedly dealt only with potency above the RDA, thereby implicitly placing a potency limit on vitamins and minerals. The proposal was withdrawn after strong opposition.

Beginning in the late 1970's, FDA turned from drug potency arguments to enforcement attempts utilizing the food additive theory to prohibit the sale of supplements which bore no claims. Essentially, the theory was that any ingredient added to a capsule or tablet rendered the resulting dietary supplement a food additive because the ingredient was added to the capsule or tablet. Under this theory, FDA could not lose, as it needed only to furnish an affidavit from one of its scientists stating that experts generally did not regard the product as safe. The actual safety of the product was never at issue.

Between 1986 and 1990, the FDA issued four health message documents for food products. This reflected FDA's initial policy with respect to the ability of food manufacturers to make limited claims about how a nutrient might prevent certain chronic diseases, such as fiber and cancer, without rendering those drug products unapproved drugs. FDA left a very narrow area for dietary supplement health messages. The level of proof required for dietary supplement claims was unrealistic in that the degree of scientific consensus and clinical data required eliminated almost all existing supplement claims.

With enactment of the Nutrition Labeling and Education Act [NLEA] of 1990, Congress directed the FDA to use the significant scientific agreement standard when deciding if foods could make claims about the relationship of the nutrient to a disease, so-called health claims. The statute specifically said that the FDA could recommend a different standard and approval procedure for supplements.

In December, 1991, FDA proposed rules implementing the NLEA, but rejected all but one claim for supplements—for calcium/osteoporosis in white and Asian women. Only one other claim has been approved since that time, the claim for folic acid and neural tube defects, and that claim was only approved after intense public pressure on the FDA.

Twice since 1991, FDA has proposed that it use the same standard and procedure for health claims for foods as on dietary supplements. In 1992, the Congress imposed a 1-year moratorium barring FDA from implementing the rule changes for 1 year. In 1993, the Senate unanimously adopted a second moratorium, but the House did not act on that legislation.

The FDA's policies on dietary supplements have not been sustained in the courts as well. FDA has asserted to Congress that in pursuing food additive allegations against dietary supplement ingredients, it is simply applying the current law in a reasonable manner and restricting its actions to products that present serious safety concerns. Two recent Federal judicial decisions, however, show that, in fact, FDA has been distorting the law in its actions to try to prevent the marketing of safe dietary supplement substances.

The FDA's efforts to ban the safe dietary supplement of black currant oil by asserting that it was an unsafe food additive were rejected last year by two unanimous decisions of two different three-judge panels in two different U.S. courts of appeals *(United States* v. *Two Plastic Drums—Viponte Ltd. Black Currant Oil—Traco Labs, Inc.*, 984 F.2d 814 (7th Cir. 1993), *United States* v. *29 Cartons of—an Article of Food—Oakmont Investment Co.*, 987 F.2d 33 (1st Cir. 1993).

In both of these cases, FDA asserted that black currant oil [BCO] was a food additive because it was added to gelatin capsules. The seventh circuit noted that "FDA has not shown that BCO is adulterated or unsafe in any way." The court described the FDA's effort as an "Alice in Wonderland" approach. Further, the decision by the first circuit described FDA's approach as nonsensical.

Despite these two setbacks in the court, the FDA recommended to the Department of Justice that petitions be filed to have these cases overturned in the Supreme Court. The Solicitor General did not file those petitions.

These examples show how the FDA has tried to protect the public against unsafe products for which there is no evidence that the product is unsafe. The FDA has also acted to restrict the information that the public may receive about dietary supplements. Folic acid is a clear example as was brought out at our Labor Committee hearing last October.

In September 1992, the Public Health Service issued a recommendation that all women of child-bearing age have adequate folic acid to prevent against birth defects. The Centers for Disease Control had made a similar recommendation 1 year before. Despite these two recommendations, and despite the fact that the FDA participated in the PHS proceedings leading up to the announcement, FDA did not issue a regulation proposing approval of a health claim for folic acid until October, 1993, 1 week before the committee's hearing on dietary supplements.

Absent approval of a health claim by the FDA, it was illegal for manufacturers or retailers to advise the public about the benefits of folic acid, even though those benefits had been endorsed by the leading Federal public health agencies.

If that isn't significant scientific agreement, I don't know what is.

What is ironic about this situation, Mr. President, is that the one element of today's health care deliberations on which there is unanimous agreement is the need for preventive health care measures and efforts to increase health promotion and disease prevention.

Unfortunately, millions of Americans do not have healthy diets and their nutrition deficit places them at risk. Senior citizens, pregnant women, infants, children, dieters, and smokers are especially vulnerable.

Debate on health care reform in the 103d Congress makes clear that improving the health status of all Americans ranks at the top of our national priorities. It is equally clear that good nutrition, which clinical research has shown to limit the incidence of chronic diseases and reduce health care expenditures, should also be an important national objective. Today, more than 100

million Americans supplement their diets through the regular or occasional use of vitamins, minerals, herbs, amino acids, or other nutritional substances. We have all heard from these consumers, and we all know how strongly they support this legislation.

Let us remember why this legislation is necessary.

It is not one Senator versus another, nor Democrat versus Republican, nor the Senate versus the House.

It is the U.S. Congress versus the Food and Drug Administration.

It is the majority of the U.S. Senate versus the continual harassment by one tiny agency which has constantly misled the American public through deliberately false and misleading statements.

It is the 250 Members of the House of Representatives against mindless Government bureaucracy, against continual overregulation, against an agency whose guiding principle has always been: One way—their way.

Here we are about to enter an unprecedented consideration of the Health Security Act, legislation which attempts to restructure one-seventh of the American economy in the name of good health for our citizens.

Here we are saying we want the American people to be as healthy as they can. Here we are meeting virtually round-the-clock to make this our top priority.

And at the same time, we are letting the FDA stand in the way of 100 million consumers' efforts to make themselves more healthy. It doesn't make any sense.

If we don't pass this bill and correct the situation, we will be parties to that charge of gridlock our constituents condemn.

There is no disagreement among us that consumers must have access to safe dietary supplements and to information about those supplements.

Any concerns that were raised about this bill, Senator HARKIN and I worked very hard to address, as I have outlined.

But let us not kid ourselves. We are starting debate on health care reform this week, and we will not have the opportunity for protracted discussion of the dietary supplement issue.

The Congress has moved a great deal on this issue since Senator REID and I introduced the original bill last April. All of this progress has been made despite the lack of cooperation by the Food and Drug Administration, an agency which, in my mind, has lied to the American public and the Congress.

And let us not forget that FDA has all the authority in the world to take bad products off the market; they just don't use it.

Critics say that the industry is misleading the public by predicting that the FDA will make dietary supplements prescription drugs, even though the FDA published a proposal soliciting comments on whether certain amino acids and herbs should be drugs. That regulation has never been withdrawn.

If you are talking about false and misleading statements, Mr. President, the FDA has a corner on the market.

I draw your attention to our Labor Committee hearing last October, when Dr. Kessler and I discussed his agency's "Unsubstantiated Claims and Documented Health Hazards in the Dietary Supplement Marketplace." I think many of us were astounded to learn of all the inaccuracies FDA made in the name of informing the Congress.

The report was so riddled with error, so flawed, that I think it calls into question the veracity of the officials who prepared it—34 of the 528 products on FDA's list simply don't exist, 142 were assigned to companies that neither manufactured nor sold the product; and 25 products were listed more than once.

At the hearing, I asked Dr. Kessler to withdraw the report; he did not.

After the hearing, BILL RICHARDSON, ELTON GALLEGLY, and I wrote to Secretary Shalala and asked her to withdraw the report; she did not. She said that the FDA would respond on my specific concerns. They sent me a report signed by a junior official which addressed none of my concerns.

At the hearing, I gave Dr. Kessler every opportunity to redeem his agency's credibility. I repeatedly asked him for documentation of his statements, even though his office had provided me with all the documentation which they said existed.

So, FDA said they would provide it for the record.

Well, that was October 21, 1993, almost 1 year ago. The record has been printed. Every single copy of the hearing has been snatched up by eager consumers. And still we have received no documentation. And at least 10 items that Dr. Kessler promised to follow up on for the record were never supplied.

Dr. Kessler brought the dog and pony show of bad products before the committee. I asked them to leave them so we could examine them and see what type of claims FDA thought were a problem.

Dr. Kessler refused, but said, "Senator, we would be happy to make copies of the labels and give you those."

That was almost a year ago and we're still waiting.

Let me tell you what has happened in those 10 months.

FDA has issued its final regulations, regulations so flawed that our only recourse, I believe, is to see them withdrawn.

And while the bureaucrats were over in FDA dotting all the i's and crossing all the t's on these regulations, what were they doing to discharge their authority under the law to protect consumers from false and misleading claims?

What were they doing? Nothing. Zippo. Zip.

You know how many seizures they have recommended against dietary supplement manufacturers since October? Zero.

You know how many prosecutions they have recommended? Zero.

And how many recalls? Just two.

I guess they were expecting us to take action against all those little bottles and boxes they brought up to the hearing, because the FDA sure didn't have any interest in doing so.

So, I go back to my original premise, Mr. President.

I have seen the enemy, and it is not anyone in this Chamber.

We have all worked long and hard. We have had to make compromises that none of us would have liked, but we have done it in the name of good public policy.

I urge that we move this issue forward and that we continue our efforts with the House to see a dietary supplement bill enacted as soon as possible.

The PRESIDING OFFICER. Is there further debate? If not, the question is on agreeing to the amendment of the Senator from Utah.

The amendment (No. 2562) was agreed to.

Mr. DASCHLE. Mr. President, I move to reconsider the vote by which the amendment was agreed to.

Mr. HATCH. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

The PRESIDING OFFICER. The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed for a third reading, was read the third time, and passed, as follows:

S. 784

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Dietary Supplement Health and Education Act of 1994".

SEC. 2. FINDINGS AND PURPOSE.

(a) FINDINGS.—Congress finds that—

(1) improving the health status of United States citizens ranks at the top of the national priorities of the Federal Government;

(2) the importance of nutrition and the benefits of dietary supplements to health promotion and disease prevention have been documented increasingly in scientific studies;

(3)(A) there is a definitive link between the ingestion of certain nutrients or dietary supplements and the prevention of chronic diseases such as cancer, heart disease, and osteoporosis; and

(B) clinical research has shown that several chronic diseases can be prevented simply with a healthful diet, such as a diet that is low in fat, saturated fat, cholesterol, and sodium, with a high proportion of plant-based foods;

(4) healthful diets may mitigate the need for expensive medical procedures, such as coronary bypass surgery or angioplasty;

(5) preventive health measures, including education, good nutrition, and appropriate

use of safe nutritional supplements will limit the incidence of chronic diseases, and reduce long-term health care expenditures;

(6)(A) promotion of good health and healthy lifestyles improves and extends lives while reducing health care expenditures; and

(B) reduction in health care expenditures is of paramount importance to the future of the country and the economic well-being of the country;

(7) there is a growing need for emphasis on the dissemination of information linking nutrition and long-term good health;

(8) consumers should be empowered to make choices about preventive health care programs based on data from scientific studies of health benefits related to particular dietary supplements;

(9)(A) national surveys have revealed that almost 50 percent of the 260,000,000 Americans regularly consume dietary supplements of vitamins, minerals, or herbs as a means of improving their nutrition; and

(B) nearly all consumers indicate that dietary supplements should not be regulated as drugs;

(10) studies indicate that consumers are placing increased reliance on the use of nontraditional health care providers to avoid the excessive costs of traditional medical services and to obtain more holistic consideration of their needs;

(11) the United States will spend over $1,000,000,000,000 on health care in 1994, which is about 12 percent of the Gross National Product of the United States, and this amount and percentage will continue to increase unless significant efforts are undertaken to reverse the increase;

(12)(A) the nutritional supplement industry is an integral part of the economy of the United States;

(B) the industry consistently projects a positive trade balance; and

(C) the estimated 600 dietary supplement manufacturers in the United States produce approximately 4,000 products, with total annual sales of such products alone reaching at least $4,000,000,000;

(13) although the Federal Government should take swift action against products that are unsafe or adulterated, the Federal Government should not take any actions to impose regulatory barriers limiting or slowing the flow of safe products and needed information to consumers;

(14) dietary supplements are safe within a broad range of intake, and safety problems with the supplements are relatively rare; and

(15)(A) legislative action that protects the right of access of consumers to safe dietary supplements is necessary in order to promote wellness; and

(B) a rational Federal framework must be established to supersede the current ad hoc, patchwork regulatory policy on dietary supplements.

(b) PURPOSE.—It is the purpose of this Act to—

(1) improve the health status of the people of the United States and help constrain runaway health care spending by ensuring that the Federal Government erects no regulatory barriers that impede the ability of consumers to improve their nutrition through the free choice of safe dietary supplements;

(2) clarify that—

(A) dietary supplements are not drugs or food additives;

(B) dietary supplements should not be regulated as drugs;

(C) regulations relating to food additives are not applicable to dietary supplements and their ingredients used for food additive purposes, including stabilizers, processing agents, or preservatives; and

(D) the burden of proof is on the Food and Drug Administration to prove that a product is unsafe before it can be removed from the marketplace;

(3) establish a new definition of a dietary supplement that differentiates dietary supplements from conventional foods, while recognizing the broad range of food ingredients used to supplement the diet;

(4) strengthen the current enforcement authority of the Food and Drug Administration by providing to the Administration additional mechanisms to take enforcement action against unsafe or fraudulent products;

(5) establish a series of labeling requirements that will provide consumers with greater information and assurance about the quality and content of dietary supplements, while at the same time assuring the consumers the freedom to use the supplements of their choice;

(6) provide new administrative and judicial review procedures to affected parties if the Food and Drug Administration takes certain actions to enforce dietary supplement requirements; and

(7) establish a Commission on Dietary Supplement Labels within the executive branch to develop recommendations on a procedure to evaluate health claims for dietary supplements and provide recommendations to the President and the Congress.

SEC. 3. DEFINITIONS.

(a) DEFINITION OF CERTAIN FOODS AS DIETARY SUPPLEMENTS.—Section 201 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321) is amended by adding at the end the following:

"(ff) The term 'dietary supplement' means—

"(1) a product intended to supplement the diet by increasing the total dietary intake that bears or contains one or more of the following dietary ingredients:

"(A) a vitamin;

"(B) a mineral;

"(C) an herb or other botanical;

"(D) an amino acid;

"(E) another dietary substance for use by man to supplement the diet by increasing the total dietary intake; or

"(F) a concentrate, metabolite, constituent, extract, or combination of any ingredient described in clause (A), (B), (C), (D), (E) or (F);

"(2) a product that—

"(A)(i) is intended for ingestion in a form described in section 411(c)(1)(B)(i); or

"(ii) complies with section 411(c)(1)(B)(ii); and

"(B) is not represented for use as a conventional food or as a sole item of a meal or the diet; and

"(C) is labeled as a dietary supplement.".

(b) EXCLUSION FROM DEFINITION OF DRUG.—Section 201(g) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(g)) is amended by adding at the end the following new subparagraph:

"(3) The term 'drug' does not include a dietary supplement as defined in paragraph (ff), except that—

"(A) an article that is approved as a new drug, certified as an antibiotic (under section 355 or 357), or licensed as a biologic (under section 351 of the Public Health Service Act (42 U.S.C. 262 et seq.)) and was, prior to such approval, certification or license, marketed as a dietary supplement or as a food, may continue to be offered for sale as a dietary supplement unless the Secretary has issued a regulation, after notice and comment, finding that the article when used as or in a dietary supplement under the conditions of use and dosages set forth in the labeling for such dietary supplement, is unlawful under section 402(f); and

"(B) an article that is approved as a new drug, certified as an antibiotic (under section 355 or 357), or licensed as a biologic (under section 351 of the Public Health Service Act (42 U.S.C. 262 et seq.)) and was not prior thereto marketed as a dietary supplement or as a food, may not be considered as a dietary ingredient or dietary supplement unless the Secretary has issued a regulation, after notice and comment, finding that the article would be lawful under section 402(f) under the conditions of use and dosages set forth in the recommended labeling for such article.".

(c) EXCLUSION FROM DEFINITION OF FOOD ADDITIVE.—Section 201(s) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(s)) is amended—

(1) by striking "or" at the end of subparagraph (4);

(2) by striking the period at the end of subparagraph (5) and inserting "; or"; and

(3) by adding at the end the following new subparagraph:

"(6) an ingredient described in paragraph (ff) in, or intended for use in, a dietary supplement.".

(d) FORM OF INGESTION.—Section 411(c)(1)(B) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 350(c)(1)(B)) is amended—

(1) in clause (i), by inserting "powder, softgel, gelcap," after "capsule,"; and

(2) in clause (ii), by striking "does not simulate and".

SEC. 4. SAFETY OF DIETARY SUPPLEMENTS AND BURDEN OF PROOF ON FDA.

Section 402 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 342) is amended by adding at the end the following:

"(f) If it is a dietary supplement that—

"(1) the Secretary finds, after rulemaking, presents a substantial and unreasonable risk of illness or injury under conditions of use recommended or suggested in labeling;

"(2) the Secretary declares to pose an imminent and substantial hazard to public health or safety, except that the authority to make such declaration shall not be delegated and the Secretary shall promptly thereafter convene rulemaking pursuant to section 701(e), (f), and (g) to affirm or withdraw the declaration; or

"(3) is or contains a dietary ingredient that renders it adulterated under paragraph (a)(1) under the conditions of use recommended or suggested in the labeling of such dietary supplement.

In any proceeding under this section, the United States bears the burden of proof on each element to show that a dietary supplement is adulterated.".

SEC. 5. DIETARY SUPPLEMENT CLAIMS.

(a) SUPPLEMENT CLAIMS.—Chapter IV of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 341 et seq.) is amended by inserting after section 403A the following new section:

"DIETARY SUPPLEMENT LABELING EXEMPTIONS

"SEC. 403B. An article, another publication, a chapter in books, or the official abstract of a peer-reviewed scientific publication that appears in the article and was prepared by the author or the editors of the publication, reprinted in its entirety, shall not be defined as labeling when used in connection with the sale of dietary supplements to consumers when it—

"(1) is not false or misleading;

"(2) does not promote a particular brand of a dietary supplement;

"(3) is displayed or presented, or is displayed or presented with other such items on the same subject matter, so as to present a balanced view of the available scientific information on a dietary supplement; and

"(4) if displayed in an establishment, is physically separate from the dietary supplements.

This section shall not apply to or restrict a retailer or wholesaler of dietary supplements in any way whatsoever in the sale of books or other publications as a part of the business of such retailer or wholesaler. In any proceeding under this section, the burden of proof shall be on the United States to establish that an article or other such matter is false or misleading.".

SEC. 6. STATEMENTS OF NUTRITIONAL SUPPORT.

Section 403(r)(1) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 343(r)(1)) is amended by adding the following new sentence at the end: "For purposes of this subparagraph, a statement for a dietary supplement shall not be considered a claim of the relationship of a nutrient or dietary ingredient to a disease or health-related condition if the statement does not claim to diagnose, prevent, mitigate, treat, or cure a specific disease or class of diseases. A statement for a dietary supplement may be made if the statement claims a benefit related to a classical nutrient deficiency disease and discloses the prevalence of such disease in the United States, describes the role of a nutrient or dietary ingredient intended to affect the structure or function in humans, characterizes the documented mechanism by which a nutrient or dietary ingredient acts to maintain such structure or function, or describes general well-being from consumption of a nutrient or dietary ingredient.".

SEC. 7. CONFORMING AMENDMENTS.

(a) SECTION 201.—The next to the last sentence of section 201(g)(1) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(g)(1)) (as amended by section 3(b)) is amended to read as follows: "A food or dietary supplement for which a claim, subject to section 403(r)(1)(B) and 403(r)(3) or section 403(r)(1)(B) and 403(r)(5)(D), is made in accordance with the requirements of section 403(r) is not a drug solely because the label or the labeling contains such a claim. A food, dietary ingredient, or dietary supplement for which a truthful and nonmisleading statement is made in accordance with section 403(r)(1) is not a drug solely because the label or the labeling contains such a statement.".

(b) SECTION 403.—Section 403 (21 U.S.C. 343) is amended by adding at the end the following:

"A dietary supplement shall not be deemed misbranded solely because its label or labeling contains directions or conditions of use or warnings.".

SEC. 8. ADMINISTRATIVE AND JUDICIAL REVIEW.

The Federal Food, Drug, and Cosmetic Act is amended by adding at the end of chapter III (21 U.S.C. 331 et seq.) the following new section:

"SEC. 311. WARNING LETTERS.

"Any warning letter or similar written threat of enforcement under the Federal Food, Drug, and Cosmetic Act constitutes final agency action for the purpose of obtaining judicial review under chapter 7 of title 5, United States Code, if the matter with respect to such letter or threat is not resolved within 60 days from the date such letter or threat is delivered to any person subject to this Act. In any proceeding for judicial review of a warning letter or similar written threat of enforcement under the Act, the United States bears the burden of proof on each element of each alleged violation of law described.".

SEC. 9. WITHDRAWAL OF THE REGULATIONS AND NOTICE.

(a) IN GENERAL.—The advance notice of proposed rulemaking concerning dietary supplements published in the Federal Register of June 18, 1993 (58 FR 33690–33700), the notices of proposed rulemaking concerning nutrition labeling for dietary supplements and nutrient content claims for dietary supplements published in the Federal Register of June 18, 1993 (58 FR 33715–33731 and 58 FR 33731–33751), and the final rules and notices published in the Federal Register of January 4, 1994 concerning nutrition labeling for dietary supplements and nutrient content claims for dietary supplements (59 FR 354–378 and 378–395) are null and void and of no force or effect insofar as they apply to dietary supplements. Final regulations and notices published in the Federal Register of January 4, 1994 concerning health claims for dietary supplements under the Nutrition Labeling and Education Act of 1990 (59 FR 395–426) shall not be affected by this section and shall remain in effect until 120 days after the date of the submission of the final report of the Commission established under section 11 to the President and to Congress, or 28 months after the date of enactment of this Act, whichever is earlier.

(b) NOTICE OF REVOCATION.—The Secretary of Health and Human Services shall publish notices in the Federal Register to revoke all of the items declared to be null and void and of no force or effect under subsection (a).

(c) ISSUANCE OF REGULATIONS.—Notwithstanding any provision of the Nutrition Labeling and Education Act of 1990—

(1) no regulation is required to be issued pursuant to such Act with respect to dietary supplements of vitamins, minerals, herbs, amino acids, or other similar nutritional substances; and

(2) no regulation that is issued in whole or in part pursuant to such Act shall have any force or effect with respect to any dietary supplement of vitamins, minerals, herbs, amino acids, or other similar nutritional substances unless such regulation is issued pursuant to rulemaking proceedings that are initiated by an advance notice of proposed rulemaking that is published no earlier than 2 years after the date of enactment of this Act, and followed by, at least, a notice of proposed rulemaking prior to issuance of the final regulation, except insofar as the regulation authorizes the use of labeling about calcium, folic acid, or other matters and does not prohibit the use of any labeling.

SEC. 10. DIETARY SUPPLEMENT INGREDIENT LABELING AND NUTRITION INFORMATION LABELING.

(a) MISBRANDED SUPPLEMENTS.—Section 403 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 343) is amended by adding at the end the following new paragraph:

"(s) If—

"(1) it is a dietary supplement; and

"(2)(A) the label or labeling of the supplement fails to list—

"(i) the name of each ingredient of the supplement that is described in section 201(ff); and

"(ii)(I) the quantity of each such ingredient; or

"(II) with respect to a proprietary blend of such ingredients, the total quantity of all ingredients in the blend;

"(B) the label or labeling of the dietary supplement fails to identify the product by using the term 'dietary supplement', which term may be modified with the name of such an ingredient;

"(C) the supplement contains an ingredient described in section 201(ff) (1)(C), and the label or labeling of the supplement fails to identify any part of the plant from which the ingredient is derived;

"(D) the supplement—

"(i) is covered by the specifications of an official compendium;

"(ii) is represented as conforming to the specifications of an official compendium; and

"(iii) fails to so conform; or

"(E) the supplement—

"(i) is not covered by the specifications of an official compendium; and

"(ii)(I) fails to have the identity and strength that the supplement is represented to have; or

"(II) fails to meet the quality (including tablet or capsule disintegration), purity, or compositional specifications, based on validated assay or other appropriate methods, that the supplement is represented to meet.".

(b) SUPPLEMENT LISTING ON NUTRITION LABELING.—Section 403(q)(1) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 343(q)(1)) is amended by adding at the end the following: "A dietary supplement may bear on the nutrition label or in labeling a listing and quantity of ingredients that have not been deemed essential nutrients by the Secretary if such ingredients are prominently identified as not having been shown to be essential or not having an established daily value.".

(c) DIETARY SUPPLEMENT LABELING EXEMPTIONS.—Section 403(q)(5) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 343(q)(5)) is amended by adding at the end the following new clause:

"(H) The labels of dietary supplements shall not be required to bear the nutrition information under subparagraph (1), but shall be required to list immediately above the ingredient listing the amount of nutrients required by the Secretary to be listed pursuant to clause (C), (D) or (E) of subparagraph (1) or clause (A) of subparagraph (2) that are present in significant amounts in the supplement.".

(d) VITAMINS AND MINERALS.—Section 411(b)(2) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 350(b)(2)) is amended—

(1) by striking "vitamins and minerals" and inserting "dietary supplement ingredients described in section 201(ff)";

(2) by striking "(2)(A)" and inserting "(2)"; and

(3) by striking subparagraph (B).

SEC. 11. COMMISSION ON DIETARY SUPPLEMENT LABELS.

(a) ESTABLISHMENT.—There shall be established as an independent agency within the executive branch a commission to be known as the Commission on Dietary Supplement Labels (hereafter in this section referred to as the "Commission").

(b) MEMBERSHIP.—

(1) COMPOSITION.—The Commission shall be composed of 7 members who shall be appointed by the President.

(2) EXPERTISE REQUIREMENT.—The members of the Commission shall consist of individuals with expertise and experience in dietary supplements and in the manufacture, regulation, distribution, and use of such supplements. At least three of the members of the Commission shall be qualified by scientific

training and experience to evaluate the benefits to health of the use of dietary supplements and one of such three members shall have experience in pharmacognosy, medical botany, traditional herbal medicine, or other related sciences. No member of the Commission shall be biased against dietary supplements.

(c) FUNCTIONS OF THE COMMISSION.—The Commission shall conduct a study on, and provide recommendations for, the regulation of label claims for dietary supplements, including procedures for the evaluation of such claims. In making such recommendations, the Commission shall evaluate how best to provide truthful and nonmisleading information to consumers so that such consumers may make informed health care choices for themselves and their families.

(d) REPORTS AND RECOMMENDATIONS.—

(1) FINAL REPORT REQUIRED.—Not later than 24 months after the date of enactment of this Act, the Commission shall prepare and submit to the President and to the Congress a final report on the study required by this section.

(2) RECOMMENDATIONS.—The report described in paragraph (1) shall contain such recommendations, including recommendations for legislation, as the Commission deems appropriate.

(e) ADMINISTRATIVE POWERS OF THE COMMISSION.—

(1) HEARINGS.—The Commission may hold hearings, sit and act at such times and places, take such testimony, and receive such evidence as the Commission considers advisable to carry out the purposes of this section.

(2) INFORMATION FROM FEDERAL AGENCIES.—The Commission may secure directly from any Federal department or agency such information as the Commission considers necessary to carry out the provisions of this section.

(3) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section.

SEC. 12. GOOD MANUFACTURING PRACTICES.

Section 402 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 342) (as amended by section 4) is further amended by adding at the end the following:

"(g)(1) If it is a dietary supplement and it has been prepared, packed, or held under conditions that do not meet current good manufacturing practice regulations issued by the Secretary under subparagraph (2).

"(2) The Secretary may by regulation prescribe good manufacturing practices for dietary supplements. Such regulations shall be modeled after current good manufacturing practice regulations for food and may not impose standards for which there is no current and generally available analytical methodology. No standard of current good manufacturing practice may be imposed unless such standard is included in a regulation promulgated after notice and opportunity for comment in accordance with the Administrative Procedure Act.".

SEC. 13. OFFICE OF DIETARY SUPPLEMENTS.

(a) IN GENERAL.—Title IV of the Public Health Service Act is amended by inserting after section 486 (42 U.S.C. 287c-3) the following:

"Subpart 4—Office of Dietary Supplements

"SEC. 486E. DIETARY SUPPLEMENTS.

"(a) ESTABLISHMENT.—The Secretary shall establish an Office of Dietary Supplements within the National Institutes of Health.

"(b) PURPOSE.—The purposes of the Office are—

"(1) to explore more fully the potential role of dietary supplements as a significant part of the efforts of the United States to improve health care; and

"(2) to promote scientific study of the benefits of dietary supplements in maintaining health and preventing chronic disease and other health-related conditions.

"(c) DUTIES.—The Director of the Office of Dietary Supplements shall—

"(1) conduct and coordinate scientific research within the National Institutes of Health relating to dietary supplements and the extent to which the use of dietary supplements can limit or reduce the risk of diseases such as heart disease, cancer, birth defects, osteoporosis, cataracts, or prostatism;

"(2) collect and compile the results of scientific research relating to dietary supplements, including scientific data from foreign sources or the Office of Alternative Medical Practice;

"(3) serve as the principal advisor to the Secretary and to the Assistant Secretary for Health, and to provide advice to the Director of the National Institutes of Health, the Director of the Centers for Disease Control and Prevention, and the Commissioner of Food and Drugs, on issues relating to dietary supplements including—

"(A) dietary intake regulations;

"(B) the safety of dietary supplements;

"(C) claims characterizing the relationship between—

"(i) dietary supplements; and

"(ii)(I) prevention of disease or other health-related conditions; and

"(II) maintenance of health; and

"(D) scientific issues arising in connection with the labeling and composition of dietary supplements;

"(4) compile a database of scientific research on dietary supplements and individual nutrients; and

"(5) coordinate funding relating to dietary supplements for the National Institutes of Health.

"(d) DEFINITION.—As used in this section, the term 'dietary supplement' has the meaning given the term in section 201(ff) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(ff)).

"(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $5,000,000 for fiscal year 1994 and such sums as may be necessary for each subsequent fiscal year.".

(b) CONFORMING AMENDMENT.—Section 401(b)(2) of the Public Health Service Act (42 U.S.C. 281(b)(2)) is amended by adding at the end the following:

"(E) The Office of Dietary Supplements.".

Mr. DASCHLE. Mr. President, I move to reconsider the vote by which the bill, as amended, was passed.

Mr. HATCH. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

SENATE LEGAL COUNSEL TO APPEAR AS AMICUS CURIAE

Mr. DASCHLE. Mr. President, I ask unanimous consent that the Senate proceed to the consideration of Senate Resolution 248, a resolution submitted earlier today by Senators MITCHELL and DOLE; that the resolution and the preamble be agreed to; that the motions to reconsider be laid on the table, en bloc; and that any statements thereon appear in the RECORD at the appropriate place as though read.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. MITCHELL. Mr. President, Senator DAVE DURENBERGER's appeal from the denial of motions to dismiss his indictment is pending in the U.S. Court of Appeals for the District of Columbia Circuit. The indictment alleges that Senator DURENBERGER submitted false claims to the Senate in regarding reimbursement for lodging in a Minneapolis condominium.

Senator DURENBERGER moved to dismiss the indictment, asserting that Senate rules underlying the indictment cannot be the subject of an adjudication in court and that a statute governing payment of Senator vouchers bars the prosecution. The district court denied the motions, and Senator DURENBERGER has taken an appeal.

The Government has moved to dismiss Senator DURENBERGER's appeal or, in the alternative, moved for summary affirmance of the district court's orders. Either action, on the basis of motion papers alone, may have the effect of limiting Senator DURENBERGER's opportunity to present the points of his appeal as fully as he believes is warranted, and is a form of consideration that the court utilizes sparingly, usually in clear-cut cases.

The Federal courts of appeals have historically given full consideration to claims in appeals by Members of Congress that civil or criminal prosecutions conflict with the constitutional separation of powers, including in a civil appeal the D.C. Circuit decided last month involving a Member of the other body. The Senate shares an interest with Senator DURENBERGER in the thorough consideration by the courts of appeals of cases presenting questions under the separation of powers.

This resolution would authorize the Senate Legal Counsel to file a memorandum as amicus curiae on the Senate's behalf solely in support of Senator DURENBERGER's receiving a full opportunity to brief and argue his appeal.

Senators may recall that the Senate appeared as an amicus curiae once before in this proceeding to support a claim that Senator DURENBERGER was making under the speech or debate clause. Senator DURENBERGER's initial indictment was dismissed because of speech or debate violations. Those problems have been cured in the present case.

In the present filing, the Senate would take no position on the merits of any of Senator DURENBERGER's claims or defenses, but only on his opportunity to be heard.

The resolution (S. Res. 248) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, is as follows:

S. RES. 248

Whereas, in the case of *United States* v. *Durenberger*, No. 94-3105, pending an appeal in the United States Court of Appeals for the District of Columbia, the powers and responsibilities of Congress and the relationship among the branches of government have been placed in issue;

Whereas, pursuant to sections 703(c), 706(a), and 713(a) of the Ethics in Government Act of 1978, 2 U.S.C. 288b(c), 288e(a), and 288*l*(a) (1988), the Senate may direct its Counsel to appear as amicus curiae in the name of the Senate in any legal action which places in issue the powers and responsibilities of Congress under the Constitution: Now, therefore, be it

Resolved, That the Senate Legal Counsel is directed to appear as amicus curiae in the name of the Senate in *United States* v. *Durenberger*, for the limited purpose of requesting the Court to give plenary consideration to the contentions of the United States and Senator Durenberger in regard to the separation of powers questions presented by the appeal.

HEALTH SECURITY ACT

The Senate continued with the consideration of the bill.

Mr. HATCH. Mr. President, I enjoyed listening to all of the Senators who spoke on health care today. As the President knows, I have taken a great interest in this matter through the 18 years that I have been in the U.S. Senate. I look forward to somehow or other crafting a health care bill that all of us can, or at least the vast majority of us, can join in.

The last thing on Earth I want to see is a health care bill that passes that only has 50 or 51 people in support of it. So all of us have to keep open minds, look for what we can and do what we can to try to bring about health care that will be beneficial for all Americans.

I was interested in the comments of the distinguished Senator from Arkansas and in the comments of the distinguished Senator from Florida that there were 17 new taxes in this bill. Actually, the Senator from Florida misspoke. There are not just 17, there are 18 new taxes in the Mitchell bill.

I am concerned about that. I have a rough time seeing how people in America are going to want to have to put up with 18 more new taxes.

I ask unanimous consent that a listing of these 18 taxes be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

THE 18 NEW TAXES IN THE CLINTON-MITCHELL BILL

(Prepared by the office of Senator Judd Gregg)

1. Standard health plans will be subjected to a risk adjustment assessment by a State organization using a methodology developed by the Secretary of HHS. This tax will be levied on large, experience-rated employers as well as community-rated plans. (Sec. 1504.)

2. States may impose a premium assessment on the insurance plans offered in the State of up to one percent of the total premiums collected, to cover administrative costs incurred by the State. (Sec. 6007.)

3. A series of tobacco taxes will be phased in, including a 45-cent per pack tax. (Secs. 7101–7103.)

4. A 1.75 percent tax will be paid by the self-insured, issuers of insurance plans, and individuals providing health insurance administrative services on the amounts received as premium and administration payments. (Sec. 7111.)

5. A premium cap is set in the form of a 25 percent excise tax that will be levied on the excess premiums of high-cost/high-growth health plans. (Sec. 7112.)

6. A "recapture" tax will raise Medicare Part B premiums for individuals whose income is above the threshold of $80,000, or $100,000 for a couple. An even higher tax is charged for those income exceeds the threshold be $15,000 single/$30,000 joint. (Sec. 7121.)

7. A 10,000% excise will be charged on some type of ammunition. (Sec. 7131.)

8. There is a 2.9 percent tax increase on certain S corporation shareholders and partners. (Sec. 7132.)

9. A 2.9 percent Medicare Hospital Insurance Trust Fund tax will be imposed on all State and local employees. (Sec. 7133.)

10. Any benefits richer than those included in the standard benefits package that an employer provides will be included in an employee's income and will be taxed as "non-permitted" benefits. (Sec. 7201.)

11. Any benefits provided through a "cafeteria plan" or flexible benefit account will be included as part of an employee's income earnings and will be taxed. (Sec. 7202.)

12. The deductibility of payments for health insurance costs will be limited. (Sec. 7204).

13. A 35 percent tax will be assessed against the aggregate employer contribution for any insurance plan that do not conform to the standard benefit package, that vary in the amount of employer-provided contribution, or that discriminate under health status requirements. (Sec. 7211.)

14. The rules for tax-exempt status as a health care organization are restricted. (Sec. 7301, 7303–7304.)

15. A 25 percent excise tax is imposed upon beneficiaries of private inurement by tax-exempt health care organizations. Additional taxes will be levied against the management of such organizations, as well as beneficiaries under specific circumstances. (Sec. 7302).

16. Special tax rules that were applied to Blue Cross/Blue Shield are repealed. (Sec. 7305.)

17. Tax penalties are increased on incorrect information returns that are filed on non-employees. (Sec. 7502.)

18. Post-retirement deductions on medical and life insurance are limited. (Sec. 7521.)

Mr. HATCH. Mr. President, today marks what would have been the first day of recess, but I am glad to be here. I am glad to be here, because health care reform should rank at the top of our legislative agenda. It must be a priority.

The only problem I have with being in session today is that I was not able to return to Utah and listen to the people there, whose valuable input is so essential to the success of our legislative process.

And never was such input more crucial.

One thing I can tell you about the people of Utah is that they are a smart bunch. They are not being fooled by the rhetoric of the Clinton-Mitchell-Gephardt health plans, plans which will ultimately provide the Government with total control over the greatest health care system there has ever been.

Utahns understand the fact that when they say "Free health care for all," it really means "Poor quality health care for all." And that is poor quality health care for all, paid for by large burdensome taxes on the hardest working Americans, the middle class.

Utahns also know the term "employer mandate" is only a fancy smoke screen for a very large payroll tax and that payroll taxes by any name mean fewer jobs.

Utahns define the phrase "shared responsibility" to mean the middle class pays more for their health care while receiving less. This is how the administration and my colleagues from the other side of the aisle would like to reward those who pay their fair share.

The people of Utah are not falling for the attractively packaged bomb of burdens known as the Clinton-Mitchell Health Security Act, and neither is the rest of America.

They did not fall for version one.

They did not fall for version two.

And they will not fall for version three which we just received today.

As you can see, these versions are not little versions. This is big stuff. And it is going to affect every American citizen for decades to come if we do not do it right.

Utahns see the Mitchell bill for what it is: a surefire way to dismantle our health care infrastructure and place the costs of renovation on the American people.

I was interested in the comments of the distinguished Senator from Arkansas saying there are not that many new bureaucracies being created. When we have had plans this big, no matter what they have been in the history of the U.S. Senate, tell me when it has not involved a tremendous expansion of bureaucracy. If anybody believes that it does not, then I have a number of things I would like to sell to you, because you sure are a sucker.

That is all I can say about it.

What is so bad about the Health Security Act? A lot.

Today, however, I want to concentrate my remarks on two of its most devastating provisions.

The first problem is that the bill promises things it cannot possibly deliver. Let us look at its impact on the elderly.

Architects of the Health Security Act promise senior citizens the peace of mind that improved access to long-term care and home-and-community-based services belong. No one can dispute the need for that.

But at what price?

When advocates of the Mitchell plan tout its improved benefits for senior citizens, they neglect to read the fine print.

The Mitchell bill is funded through incredible cuts in the Medicare Program, cuts which I predict will jeopardize the whole future of Medicare in this country.

Congressional Budget Office calculations indicate that Medicare cuts in the Mitchell bill between now and 2004 total $198.8 billion. How on Earth can Medicare absorb cuts like that and still be viable, and keep up the high quality of work and medical care and treatment that the elderly have come to expect in this country? There is no way they can.

How can doctors absorb $10 billion in payment reductions and still agree to participate in Medicare? We are already having substantial problems in Utah with physicians who do not want to participate in Medicare because of its low payment rates. This bill will drive physicians out of the Medicare Program.

And it is not just Utah; it is everywhere in the country.

How can hospitals and nursing homes absorb $97.2 billion in cuts and still remain open?

How can clinical labs and patients who use their services absorb $21.2 billion in cuts? How can the home health program—one that I helped to bring into existence, worked hard to get it into existence, and which means so much to people whose lives are coming to an end-and for families who have to watch over them but have to work and need somebody to care for them. How can home health care programs see costs cut $63.9 billion and still remain viable? The answer is simple. They cannot. I have a problem with provisions in any bill which cut too deeply into Medicare. How the Mitchell bill jeopardizes Medicare is one of the hidden stories in this debate, and we ought to get it in the open right now.

Indeed, at the same time we are cutting Medicare, we are offering our citizens a new entitlement: prescription drug coverage. This, too, is a heartless hoax which victimizes the elderly. The drug benefit promised by the Mitchell plan would cost almost $100 billion in its first 6 years of operation, from fiscal years 1999 to year 2004.

What are we getting for our money? Not what you think. Fifty-five percent of the elderly now have prescription drug coverage. The deductible for retirees is typically $100 or less. Contrast that with the Mitchell bill. Estimates indicate that it would cover only a fraction of Medicare beneficiaries, 35 to 42 percent, with a deductible of about $650 and a new cost of $100 billion. What a deal.

Mr. President, nothing is as certain as death and taxes. This bill proves that point: cuts that surely mean the death of a Medicare program, and taxes the public would not believe. The Clinton-Mitchell health care bill contains at least 18 outright tax increases. Most of these are hidden taxes on the middle class that will sneak up on taxpayers like thieves in the night.

CBO numbers show that in the next decade the bill would raise taxes by a net amount of over a quarter of a trillion dollars. This means that every family of five in Utah will pay more than $5,100 in additional taxes because of this bill.

One of the examples of the hidden tax is the 1.75-percent levy on all insurance premiums. This tax will raise $75 billion over the next decade and will be paid, directly or indirectly, by almost everyone. Individuals who buy their own insurance, or who share the cost of health insurance premiums with their employer, will pay the tax directly.

In the case of employer-provided insurance, the tax on premiums will be passed on to employees in the form of lower wages, reductions in benefits or lost jobs.

It is ironic that a bill designed to keep the costs of health care down should immediately raise those costs by assessing a tax on health care insurance premiums.

Another stealth tax in the Clinton-Mitchell bill is the complicated 25 percent tax on health insurance plans whose premiums grow faster than a targeted growth rate. This tax, estimated to raise over $70 billion, would apply to virtually all health plans, according to the CBO.

Although this tax is a barely disguised method of price control, it is obvious already that it will never work. If it were an effective way of holding down premium costs, it would not raise much, if any, revenue.

I was shocked to learn that analysts have forecast that the Mitchell bill will cost Utah businesses $547.6 million a year starting in the year 2002, the year that the employer mandate would be triggered. That says it all.

Mr. President, I am not here to oppose health care reform. As I said, I believe we ought to work together to try and come up with a workable solution. I am here to oppose a version of health care reform that will doom the greatest health care system in the world and, at the same time, suck America's economy right down the drain.

I believe health care reform is possible.

I believe health care reform is desirable.

I believe health care reform is necessary.

But not reform like this.

The architects of the Clinton bill, however it is packaged, should get back to the drawing board and maybe sit down with some of us and work this out, for surely this house of cards is going to tumble.

I am very concerned about it, because I have seen through the years how difficult it is to get small, but effective, health care bills through, from home health care to drug price competition, patent term restoration, to the orphan drug bill, to S. 784, the dietary supplement bill. It takes an inordinate amount of work to get these bills through, and they are part and parcel of the health care program. I can name dozens and dozens of others that I have helped pass or worked on to get through.

I am the only Senator on all three committees involved in the health care debate. The Finance Committee which my dear friend from Arkansas and my dear friend from West Virginia and dear friend from South Dakota are all on, and the Labor and Human Resources Committee which has worked long and hard and, I felt, came up with a horrendous bill which is now part of the Mitchell bill; and, of course, the Judiciary Committee, all three of which have a lot to do with health care.

The Judiciary Committee is really concerned about medical liability issues, about antifraud issues, about ERISA issues. The Finance Committee is worried about almost everything involving taxes, money, and things involving Medicare, Medicaid, Social Security, ERISA, and so forth. The Labor and Human Resources Committee has almost all the public health issues.

Frankly, I am very concerned about what we are doing. But I really believe that this bill would be an absolute albatross around the necks of everybody in America, if we pass it in its current form. Nobody believes we are going to do that. And I want to pay tribute to everybody who is working hard and trying to come up with something that might really work well.

I will not talk any longer today on this, but I wanted to make some of these points, because I am very concerned that we are leading America down a path that is going to be almost impossible to get out of once we start down it. If we do it the wrong way, we are all going to be sorry about it. Of course, we will probably be dead and gone while our children are saddled with this albatross the rest of their lives.

RECESS UNTIL MONDAY, AUGUST 15, 1994, AT 10 A.M.

Mr. HATCH. Mr. President, If there is no further business to come before the Senate today, and I see no other Senator seeking recognition, I now ask unanimous consent that the Senate stand in recess as previously ordered.

There being no objection, the Senate, at 5:07 p.m., recessed until Monday, August 15, 1994, at 10 a.m.